# Acceptability of alternative treatments for problematic gambling

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# Table of Contents

# List of Tables and Figures

## Abstract

### Background & objective

Cognitive Behavioural Therapy (CBT) and Motivational Interviewing (MI) have been the treatment of choice for problem or pathological gambling in the field in Western countries, and their efficacy has been supported by a considerable empirical research. Alternative treatments are little known; and such treatments for minority ethnic populations have been scarce. This study adopted Kazdin's procedures for assessing the acceptability of treatments (Kazdin, 1980a, 1980b, 1981) to test alternative treatments of problem or pathological gambling as a part of the broadening of treatment choices. This thesis presented 2009 survey results from counselling service providers in New Zealand on the acceptability of alternative treatments to problem or pathological gambling. The thesis, therefore, reports the responses of counsellors to counselling vignette case examples, not the views of actual clients viewing counselling.

### Methods

The survey pack was distributed to counselling service providers in New Zealand. The survey included descriptions of sixteen vignettes of case examples of counselling treatments. Categories of clients in the vignette case examples included two genders (male, female) and three ethnicities (Pakeha, Maori, and Asian). Four counselling treatment conditions were selected from Solution-Focused Brief Counselling (SFBC), SFBC+Multicultural Counselling (SFBC+MC), Cognitive-Behavioural Therapy (CBT), and Motivational Interviewing (MI). CBT and MI were only administered to Pakeha clients for the purpose of comparison of the alternatives.

Two measurements were used. The first a modified *Problem Gambling Treatment Evaluation Inventory* (TEI) was used to measure the acceptability levels of the alternative treatments for problem or pathological gambling. The *Cross-Cultural Counselling Inventory-Revised* (CCCI-R) was used for measuring the perceived cross-cultural competency of counsellors depicted in the vignette case examples.

## Findings

Counsellors' ratings of the vignette case examples revealed the following findings:

Measurement 1: *Problem Gambling Treatment Evaluation Inventory* (TEI). Overall, 1) The survey results of TEI questionnaires showed significant main effects across the four treatment conditions and the three client ethnicities, and there was no difference according to client genders. 1.1) SFBC+MC and SFBC were slightly more acceptable than CBT, and much more acceptable than MI. 1.2) The TEI scores for Pakeha clients were much higher than for Maori clients, and the scores for the Asian clients were in between. 2) There was a significant interaction effect between the four treatments and the three client ethnicities. 2.1) For Maori clients: SFBC+MC was much more acceptable than SFBC; for Pakeha clients: SFBC+MC was the most acceptable, closely followed by SFBC, CBT, then MI; and for Asian clients: SFBC was more acceptable than SFBC+MC. 2.2) SFBC+MC was most acceptable to Maori clients across all treatments and ethnic groups. 2.3) The variation in acceptability ratings for SFBC was larger than for SFBC+MC in Maori and Asian clients, and less variable in Pakeha. 2.4) Maori clients had the largest mean variation between SFBC and SFBC+MC, and Pakeha clients had the smallest mean variation.

Measurement 2: *Cross-Cultural Counselling Inventory-Revised* (CCCI-R). The survey results of the CCCI-R showed significant main effects across the four

treatment conditions and the three ethnicities. 1) The counsellors depicted in the vignette case examples under the SFBC+MC treatment condition were rated with the highest mean competence score and least variability across all the treatments and the ethnicities, the MI treatment condition were rated with the lowest mean score, CBT and SFBC were in between. 2) The counsellors described in the vignette case examples were rated more culturally competent with Pakeha clients and Maori clients than with Asian clients in the vignette case examples, the rating levels for both Pakeha and Maori were similar. 3) The Maori client in the vignette case examples had the largest mean gap between SFBC and SFBC+MC, and Pakeha client in the vignette case examples had the smallest mean gap.

## Clinical implications

The tests of the acceptability of alternative treatment for problem or pathological gambling could provide useful information about 1) whether the above alternatives would be recommended or selected by the counselling service providers in their clinical practice, 2) which treatment would be more/less preferred by which ethnic group, 3) whether it would work or be worth the efforts to introduce or promote the above alternatives to the counselling service providers, 4) what needs to be explored for increasing levels of the acceptability of alternative treatment to problem or pathological gambling, 5) adding training in the techniques to counsellors training programme and curricula.

The limitation of this study was discussed and future research was suggested.

# Introduction

Problem or pathological gambling behaviour is a growing concern across individuals, families, communities, and the public sphere since various gambling activities have become a legalized industry in many Western countries (Lesieur & Rosenthal, 1991). For example, there has been a sharp increase in monetary expenditure on gambling activities in New Zealand from $155-million in 1982 to $2028-million in 2009 (www.dia.govt.nz). In New Zealand, it was estimated that the prevalence rate of problem or pathological gambling was 1.3% (Abbott & Volberg, 1994, 2000). Problem or pathological gambling can lead to a wide range of personal and social issues, such as bankruptcy, chronic family relationship distress, neglect of children, employment disruption, cross-addiction, criminal activities, and serious destructive behaviours including domestic violence, self-harm, and suicide (Abbott, Cramer, & Sherrets, 1995; Blaszczynski & Farfels, 2003; Daughters, Lejuez, Lesieur, Strong, & Zvolensky, 2003; Gaudia, 1987).

Compared to established treatments for alcohol abuse and substance dependency, treatment for problem or pathological gambling is in its infancy (Toneatto & Ladouceur, 2003). Commonly used treatments for problem or pathological gambling include individual or family counselling/psychotherapy, group psychoeducation-based programs, self-help groups, e.g., Gambling Anonymous (GA), pharmacotherapy (Dannon, Lowengrub, Musin, Gonopolsky, & Kotler, 2007; Grant & Kim, 2002), and natural recovery (Hodgins, Wynne & Makarchuk, 1999).

Two counselling therapy approaches that have been the most empirically studied as treatment for problem or pathological gambling are Cognitive-Behavioural Therapy (CBT) (Blaszczynski & Silove, 1995; Coman, Evans, & Burrows, 2003;

Hodgin & Petry, 2004; Petry, 2005; Petry, Ammerman, Bohl, Doersch, Gay, Kadden, Molina & Steinberg; 2006; Sylvain, Ladouceur, & Boisvert, 1997) and Motivational Interviewing (MI) (Freidenberg, Blanchard, Wulfert, & Malta, 2002; Hodgins, Currie & el-Cuebaly; 2001; Hodgins & Diskin, 2008; Takushi, Neighbors, Larimer, Lostutter, Cronce, & Marlatt, 2004). Generally, CBT and MI are the treatment of choice in the field. Little is known about other alternative counselling treatments for problem or pathological gambling. The range of treatments needs to broaden (Hodgins, 2005) because clients may not respond to a particular treatment in the same way; some might do well, others might not (Hill, Helms, Spiegel, & Tichenor, 1988). However, studies on alternative counselling treatments for problem or pathological gambling are limited, particularly in respect of treatments for ethnic minorities and non-Western individuals.

Problem or pathological gambling and ethnic culture are closely related in terms of problem or pathological gambling's development, maintenance, prevalence rates, help-seeking behaviours, and values and beliefs systems (Raylu & Oei, 2004). A number of studies have found that certain ethnic populations, such as indigenous people and ethnic immigrant minorities have a higher risk of developing problem or pathological gambling than Caucasian groups (Abbott & Volberg, 1996). However, these populations have often been under-users of mainstream treatment services. This could be due to a large gap between what is offered in the mainstream services and the populations' own cultural traditions and preferred helping practices. Additionally, the mainstream services could be further limited when the treatment procedures are unfamiliar or too foreign to clients' cultural backgrounds, which could prevent ethnic minority people from getting counselling assistance when they need it. The need to develop culturally sensitive and responsive treatment for problem gambling is clear

(Raylu & Oei, 2004), and treatments applicable to minority ethnic populations have to be developed.

The work on expanding treatment choices and exploring alternative treatments to target behaviours begins with addressing *Social validity* (Wolf, 1978) issues. This is because empirically supported treatments may not necessarily lead to clinical progress when the treatment procedures are disliked by the consumers and/or are unacceptable to professional service providers. This means that effective treatments require three compatible parts: 1) The development of the scientific, research-based treatment programs, 2) assessment of the consumers' expectations and requests, and 3) assessment of views and needs of treatment providers. It is essential to test the levels of compatibility between the programs and the target consumers before taking any further steps. It is important for investigators of alternative treatments to find out how potential service users would judge and evaluate the treatments before implementing them, just as it is important to know what consumers want. This study took the path of testing the acceptability of alternative treatments for problem or pathological gambling to treatment providers serving ethnic minority populations in the New Zealand context.

## Social Validity Theory and Acceptability of Treatment

*Social validity* theory (Wolf, 1978) refers to the role of *social importance* in conducting applied behavioural research and practice, key aspects including treatment goal-setting, *acceptability* of treatment procedures, and treatment evaluation (Kazin, 1980a; Foster & Mash, 1999; Wolf, 1978). *Social validity* theory was introduced by applied behavioural analysts addressing three key questions of research. 1) Is a given treatment goal one that consumers (including clients, significant others, third party payers, clinicians) and their community would be

interested in and want to achieve? 2) Is the treatment procedure acceptable and appropriate to the consumers and their community? 3) Is the treatment outcome satisfactory and desirable for the consumers and their community? Answers to these questions have to come from consumers themselves instead of researchers or investigators. In contrast to researchers who use only objective-oriented measurements and data collection, researchers using *social validity* consider and include subjective measurements from consumers, and from other representing communities, significant others, and service providers and professionals.

Wolf advocated that subjective measurements could help researchers or investigators obtain valuable data regarding consumers' preferred treatment goals, their inner experiences of the treatment procedures, and their judgments of the treatment outcomes. These data would provide information on whether it would be worth the effort to introduce a particular treatment when consumers disliked the treatment procedures, were not interested in the treatment goals, and viewed the treatment outcomes as irrelevant to their circumstances. Also the data could offer information on barriers to treatment, and what can be done to modify treatments to better fit consumers' treatment needs.

*Social validity* researchers were aware of the reliability issues of subjective data, they consider measured data alongside objective data derived from rigorous scientific empirical systems for developing and delivering alternative behavioural treatment programs (Kazdin, 2003, Wolf, 1978).

From the social validity perspective, the researchers would not present themselves as experts with all the right answers; rather they would invite potential consumers to participate in behavioural change activities, communicate with their potential consumers, and weigh their feedback on the whole treatment activity. Subjective

judgements made by consumers about treatment programs appear to be necessary and helpful (Kazdin, 2003, Wolf, 1978). In other words, the relationship between clinical scientific research and treatment program delivery is like that of a product and the market, they are interdependent. Products can create a new market while the market can either bring the products to life or block entry to them.

Research methods built upon social validity investigation process is known as the assessment of acceptability of alternative treatments, a procedure developed by Kazdin.

Treatment acceptability refers to a given behavioural intervention procedure that is judged by potential consumers (clients, significant others, lay persons, or clinicians) on its *appropriateness*, *fairness*, and *reasonableness* as if it is to be implemented for a target behaviour (Kazdin, 1980a). The purpose of testing the degrees of acceptability is to find out whether a treatment program is evaluated as being important and relevant from the consumers' point of view; whether the program procedure is perceived as being fair and appropriate; and if the effects/goals of the treatment are judged as being acceptable.

As it takes into account the consumers' perspective, acceptability research can provide information for selecting suitable treatments that may be more preferred by consumers, with low barriers to implementation and better outcomes. An intervention may be supported by empirically-based efficacy studies, but may be rejected or encounter resistance in implementation when consumers show a low degree of acceptance of it.

The acceptability of alternative treatments assessment is independent of the assessment of the efficacy of treatment programs (Kazdin, 1980a, b, 1981, 2003). Acceptability treatment studies are not only useful in different community and social

contexts but also in diverse cultural contexts. For example, an empirically-based treatment procedure developed in the Western context may not be accepted by non-Western clients. This can help explain partially why non-Western immigrant clients are under-utilizing mainstream mental health services, and often have a higher rate of premature termination (Barrett, Chua, Crits-Christoph, Gibbons, & Thompson, 2008; Sue & Sue 2008).

Researchers doing treatment acceptability studies often use *experimental analogue studies* that present vignette clinical case examples, describing the target problem and treatment procedures, then asks respondents (clients, significant others, lay-professionals, staff, or clinicians) to rate the acceptability of the treatment procedures to the target problems and client (Foster & Mash, 1999). The rating scale that is frequently used was developed by Kazdin, and is a 15-item Treatment Evaluation Inventory (TEI) (Kazdin, 1980a, 1980b, 1981), using 7-point Likert scales.

Treatment acceptability research started with a focus on disruptive behaviours in children. There are extensive studies on the topic which were rated by students and staff in educational institutions (Cavell, Frentz, & Kelly, 1986; Eckert, Hintze, & Shapiro, 1997; Kazdin, 1980b, 1981; Elliott, Witt, Galvin, & Moe, 1986); adults in a community setting (Blampied & Kahan, 1992); and staff in hospitals (Kazdin, 1984; Tarnowsky, Kelly, & Mendloitz, 1987). Acceptability research has expanded to include clinical problems in adult populations, such as sex and marital therapies (Wilson & Flammang, 1990; Wilson & Wilson, 1991); treatment for depression (Banken & Wilson, 1992), and therapeutic programs for eating disorders (Varnado-Sullivan & Horton, 2006).

The present study used *experimental analogue studies* to test the acceptability to counsellors of alternative treatments for problem and/or pathological gambling with diverse cultural clients. The researchers recognised that the acceptability of alternative treatments to actual clients is of even greater interest, but logistical problems led to selecting counsellors as the target group. In practice, a novel therapy must be acceptable to both practitioners and to clients if it is to become widely available.

## Studies on treatments for problem or pathological gambling

**Empirical research on cognitive behavioural therapy (CBT):** From a CBT perspective, problem gamblers hold a core belief system that tends to distort reality, leading to serious errors in thought processes and judgment, they often use superstitions for direction and guidance, and pursue the illusion of control. Starting and continuing Gambling behaviours has to do with their reinforcers (Blaszczynski & Silove, 1995; Hodgins & Petry, 2004; Walker, 1999). Often a wind-fall win is the beginning of a gambling career. Chronic losses and irregular wins can keep this career going. Apart from these monetary reinforcers, problem gamblers can use gambling to get other kinds of reinforces, such as excitement, escape from other life problems, and/or dysphasic emotions, socializing, etc (Hodgins, Wynne & Makarchuk, 1999).

CBT challenges the gamblers' core belief systems, and attempts to change their self-defeating behaviours, facilitating alternative and healthy ways to get their reinforcers, via alternative sources of excitement and socialization.

In their controlled study on the efficacy of CBT for problem or pathological gambling, Sylvain, Ladouceur, and Boisvert (1997) used cognitive correction of erroneous perceptions about gambling, problem-solving training, social skills

training, and relapse prevention on twenty-nine male respondents with problem or pathological gambling, who were randomly assigned to either individual treatment or wait-list conditions. Fourteen respondents were under the treatment condition and received an average of 16.7 hours of the therapy. All results, post-test and 6-month and 12-month follow-ups, showed significant problem or pathological gambling reduction between the treatment group and the wait-list.

Petry and her colleagues (Petry, Ammerman, Bohl, Doersch, Gay, Kadden, & Steinberg, 2006) conducted a study on the efficacy of CBT for problem or pathological gambling with a larger sample of 231 respondents. The study included three treatment conditions: GA (Gambler Anonymous) as a real-world control condition, GA+CB workbook, and GA+ 8 CBT individual sessions. The outcome results at 1-month, 2-months, 6-months, and 12-months, supported the superiority of CBT for problem or pathological gambling reduction and the maintenance of treatment progress.

Dowling and colleagues conducted a study on the efficacy of CBT for female problem or pathological gambling (Dowling, Smith, & Thomas, 2006). Nineteen of 39 respondents completed the program and the 6-month follow-up. The respondents were randomly assigned to the treatment group or the wait-list group. The treatment group received 12 sessions (1.5 hours per session) of CBT. The results showed a significant improvement in problem or pathological gambling reduction as well as psychological function for those in the treatment group, and 89% of the respondents no longer met the criteria of problem or pathological gambling.

**Empirical research on motivational interviewing (MI):** From a MI perspective problem or pathological gambling, like other addictive behaviours, such as alcohol abuse or substance dependency, is associated with conflicting motivations and often

oppositional wants and needs within problem gamblers, resulting in losing self-control over key aspects of their life (Hodgins & Diskin, 2008). The goal of treatment for addictive behaviours is to integrate those conflicting elements which would facilitate addictive behavioural change (Miller & Rollnick, 1991). Recovery from addictive behaviours is viewed as a process, rather than a one step rebirth, involving different stages of change, precontemplation, contemplation, preparation, action, maintenance (Prochaska & Di Clemente, 1982), clients' levels of motivation and commitment for change (Hodgins, 2001), and their degrees of self-efficacy (Bandura, 1977).

MI therapists have faith in clients who are believed to be capable of becoming their own change agents when they become motivated and are committed to change. MI therapists have a focus on creating therapeutic movement in the interviewing process for enhancing clients' level of motivation and commitment, facilitating them to enter the process of change, make progress, and maintain changes (Miller & Rollnick, 1991).

In their controlled outcome study, Hodgins and his colleagues (Hodgins, Currie, & el-Guebaly, 2001) used a MI+CBT workbook, a brief telephone interview+ the workbook, a brief telephone interview+wait-list on 102 respondents in treatment and a wait-list control group. The 12-month follow-up results supported the MI+CBT workbook more than the other two conditions. In their 24-month follow-up (Hodgins, Currie, el-Guebaly, & Peden, 2004), MI showed better outcome reduction in problem or pathological gambling.

Diskin and Hodgins (2009) conducted a single session MI for problem or pathological gambling. Eighty-one respondents were randomly assigned to the MI (n=42) group or the SCID (Structured Clinical Interview for DSM-IV) II control

intervention (CI) group (n=39), and both groups received a self-help workbook. The results showed, at 1-month, 3-months, 6-months, and 12-months, a problem or pathological gambling reduction in both groups, and MI showed a better outcome in reduced money and time spent gambling and alleviated overall psychological distress more than the CI.

In a single case study, Kuentzel and colleagues (Kuentzel, Henderson, Zambo, Stine, & Schuster, 2003) used MI and Fluoxentine for problem or pathological gambling. The client received 4 MI sessions (1 hour per session) and a 10-week trial of taking fluoxetine. Compared to the baseline data, at the end of the treatment and the 3-month follow up, the client had reduced money spent and time consumed on gambling activities by a significant amount, no longer met the criteria for problem or pathological gambling, and had an increased psychological functioning.

The above CBT and MI empirical studies, along with many other researches, have supported the efficacy of CBT and MI for problem or pathological gambling for Western clients.

## Alternative Treatments for Problem or Pathological Gambling

### Solution-Focused Brief Counselling (SFBC)

SFBC was originally developed from the Brief Family Therapy Centre, Milwaukee, Wisconsin, in the early 1980s, in response to the needs of people who often experienced chronic and multiple difficulties and did not have sufficient resources to undertake long-term psychotherapy and developing insight. They needed a brief and practical therapy to target presenting issues and then get on with life.

From a SFBC perspective, a given presenting problem is conceptualized as an unfit solution that clients have attempted to apply to their primary situations. Thus to find a better fit solution can be an independent process separated from understanding and analyzing the presenting problem or exploring the history of the problem (de Shazer, 1988, 1991). In other words, understanding a problem is one thing, and creating a solution is another; the birth of solutions does not depend on problem identification and assessment.

SFBC adapts the social constructionist view on the important role language plays in meaning-making, and social interaction plays in shaping reality. From this point of view, meanings of events or experiences can be changeable when language is purposely selected, manipulated, and communicated; the reality is not fixed as it can be created and co-constructed through social interaction and relationship (Gergen, 1985).

SFBC therapists carefully craft their language to draw clients' attention to their strengths and solution-making potential. They invite clients as co-counsellors to participate in the solution-finding process, valuing a working relationship with

clients. The central task of SFBC is to identify workable alternatives within clients' existing resources, amplify them, and encourage clients to use more of them.

In SFBC, the alternatives refer to *exceptions* when the problem is absent or has less negative effect on clients' day-to-day functioning. SFBC focuses on making a difference in the future, working with what clients want to have happened, and what steps are necessary to take at present. SFBC therapists ask a *miracle question* to generate a fresh look at the future. These questions are particulars helpful when clients do not recognize their existing exceptions. Scaling questions are used to work on goal-setting, and to measure and evaluate the progress clients have achieved (De Jong & Berg, 2002).

There is a lack of empirically controlled studies on SFBC as the majority of existing research consists of case studies and theoretical application. The few literature reviews on treatment outcome studies of SFBC have supported the effectiveness of SFBC (Gingerich & Eisengart, 2000; Corcoran & Pillai, 2009; Wehr, 2010), and the model has been applied to a wide range of common clinical problems and diverse populations, such as substance dependence, alcohol abuse, mild psychological difficulties, relationship issues, children and adolescent problematic behaviours, and intimate partner violence etc (Berg Reuss, 1998; De Jong & Berg, 2002; Miller & Berg, 1995; Miller, Hubble, & Duncan, 1996). Studies on the application of SFBC to problem or pathological gambling are few. Berg and Briggs (2002) presented a case example of working with a male problem or pathological gambling client to illustrate the application of SFBC.

## Research on the Application of Multicultural Counselling (MC)

Multicultural counselling was developed in the 1970s in response to growing concerns about applying Western-oriented counselling treatments, as universally applicable to all non-Western clients. Pedersen suggested that multicultural counselling was a *fourth force* or a *generic approach* in the counselling field after psychodynamic, behavioural, and humanistic approaches. Multicultural counselling is not intended to replace these three approaches, rather it would be able to be incorporated with other counselling approaches to address and deal with the mental health needs of culturally diverse clients effectively. Multicultural counselling can enhance the relationships between the professionals and culturally diverse clients, bridging the cultural gap between Western and culturally diverse people, making psychological service work effectively in a multicultural setting (Pedersen, 1990).

Multicultural counselling scholars have questioned counselling activities limited by the culturally encapsulated worldview that tended to accept cultural assumptions or stereotypes as truth and facts, leaving little space for new information and evidence-based knowledge to emerge, and reluctantly adapting and accommodating to an ever-changing cultural landscape (Wrenn, 1985). These scholars believed that this kind of encapsulated view and practice ignored culture diversity, which could contribute to racial oppression of minority ethnic people (Sue, 1978).

Multicultural counselling has a focus on how to deliver best services to culturally diverse clients (Arredondo, Rosen, Rice, Perez, & Tovar-Gamero, 2005) in societies where the majority of the population are Westerners, the mainstream psychological social services are Western-oriented, and the theory, research, practice, and training system reflect the Western worldview. They introduced multicultural counselling as a powerful movement to challenge the professionals' ways of perceiving, thinking,

being, and doing in a multicultural context. They argued that counsellors need to have a better understanding of their clients' thoughts, emotions, and behaviours change which often occur in the counselling process (Sue, 1978, Sue & Sue, 2008).

Multicultural counselling can provide a necessary conceptual framework to guide all kinds of counselling activities, such as knowledge building, research, training, and practice, as well as professional and personal development of counsellors and counsellor educators (Pederson, 1990, 1991; Sue, 1978; Sue, Arredondo, & McDavis, 1992; Sue & Sue 2008). It encourages skill-development in communication, interaction, language, relationship-enhancement, looking at the presenting issues and solutions from a holistic view, often including a cultural identity developmental process, and considering the social and political impact. It discourages a psychopathology-focused and individual deficit approach (Sue & Sue, 2008). For example, Aredondo et al's (2005) MC 10-year content analysis of the *Journal of Counselling & Development* found 102 published studies met their research criteria, 78% of the 102 were applicable to clinical practice, and pathology was not a focus.

Existing MC research has found positive outcomes of application of the MC. In their 40-year review of MC outcome research, Andrea and Heckman data found 211 MC published outcome studies, and 53 out of the 211 met their study criteria. Thirty-one of the 53 studies examined changes in the psychological functioning of the clients (Andrea & Heckman, 2008).

A *Multicultural counselling competencies* (MCC) conceptual model was introduced, suggesting a matrix of 3 characteristics x 3 dimensions (*awareness, knowledge, skills),* and thirty-one criteria for counselling professionals to use in their research, training, and practice (Sue, Bernier, Durran, Feinberg, Pedersen, Smith,

Vasquez-Nuttall, 1982; Sue, 1982; Sue, Arredondo, & McDavis, 1992; Sue & Sue, 2008). This model was revised and developed, and then adapted by the American Psychological Association (2003) as guidelines for professional standard practice.

Based on this model, a number of MC competence instruments were developed, and the *cross-cultural counselling inventory-revised* (CCCI-R) (LaFromboise, Coleman, & Hernandez, 1991) was the first MC instrument to have received most empirical attention. It was designed for supervisors to use when supervising counsellors to assess their MC competency (Sabnani & Ponterotto, 1992; Ponterotto, Rieger, Barrett, & Sparks, 1994). It is the only available observer-rated measurement (Worthington, Soth-McNett, & Moreno, 2007). The CCCI-R was chosen for this project alongside Kazdin's TEI, which will be discussed below.

## Combining SFBC and MC

**Philosophy assumptions: social constructionism vs multiculturalism**: SFBC adapts a *social constructionism* philosophy. One social constructionist argument is:

> *From the constructionist position the process of understanding is not automatically driven by the forces of nature, but is the result of an active, cooperative enterprise of persons in relationship* (Gergen, 1985, p.267).

Social constructionism is incorporated in SFBC interviewing. In SFBC, the interaction between clients and counsellors plays a key role in the interviewing process and outcomes. The interaction is viewed as a co-constructing process for alternative solutions to be created, emerge and develop. As clients are invited to engage with and participate in constructing a solution-building process with their counsellors, the alternative solutions are likely to be relevant and better fit to clients' circumstances. Additionally, the interaction process itself can empower clients to

take an active changing agent role to leave their problematic behaviours with dignity (De Jong & Berg, 2002; Duncan, Hubble, & Miller, 1997).

Multicultural counselling is based on multiculturalism which represents both *etic*, e.g., cultural universalism, and *emic*, e.g., cultural relativism perspectives. The former looks at all variables for classifying people, such as, ethnicity, age, gender, sexuality, religion, disabilities, physical appearance, etc, claiming that the differences are universal in nature, therefore, all interactions between people are intercultural activities without exception. The latter focuses on ethnic cultural variables with the recognition of other disadvantaged social groups, and multicultural counselling applies specifically to intercultural contact between clients and counsellors (Pedersen, 1991; Sue & Sue, 2008).

Social constructionism and multiculturalism are compatible philosophies. Both are open to explore multiple layers and diverse perspectives of reality, looking at the process of constructing reality instead of discovering a fixed reality, and accepting that reality is multifaceted and shaped by many contextual factors, such as socioeconomic and political, historical, ethnic, cultural, environmental, and geographic domains (Bronmell, 2008; González, Biever, & Gardner, 1994).

***The content: from problem to solution vs from Western to cultural diversity:***

The signature of SFBC is a paradigm shift from problem-oriented approaches to a non-problem strengthen-based modality. This is widely used by social workers, family and marriage counsellors, school counsellors, alcohol and drug counsellors, and general health counsellors. Furthermore, a number of studies support the usefulness and suitability of the application of SFBC to diverse cultural populations, such as SFBC with Muslim families (Valiante, 2003), with Asian elders and their families (Lee & Mjelde-Mossey, 2004), and with Iranian immigrants (Maryam,

2006). In these studies, these authors claimed that the core elements of SFBC and its brief and action-based features were appropriate to these culturally diverse clients' counselling needs.

SFBC is one of hundreds of developed psychotherapy/counselling modalities. MC is not viewed as a modality, but as a movement challenging the traditional view that Western psychological knowledge and practice are universally valid and applicable. As SFBC values clients' expertise in their own circumstances and works co-operatively with them to create solutions, MC respects clients' diverse cultural backgrounds, integrating their cultural needs into a (Western) psychological service system. SFBC strives to empower clients and counts their own strengths and resourcefulness, and MC encourages ethnic minority clients to have their own voices in the mainstream system. SFBC counsellors take a 'not-knowing' position to be curious to their clients' circumstances, and MC counsellors examine their own assumptions and biases in relation to culture, and be open to experience the diverse cultures that clients bring into the counselling sessions. Both SFBC and MC emphasise equal relationship between counsellors and clients.

***The process: strength-based:*** Similarly to SFBC, MC is a non-pathologising approach, emphasizing counsellors' multicultural counselling competency, validating clients' perspectives on health and illness, and is open to alternative ways of healing practice, ensuring counselling work that is consistent with clients' circumstances and values and belief systems (Sue & Sue, 2008). Both approaches argue that positive therapeutic changes can occur when clients' own worldviews and belief systems are respected, their voices are heard, their own resources and strengths are valued, and their cultural identities are validated. When a collaborative and partnership working relationship is in place, counsellors' competency, professionally and culturally, is

established and developed, and the professional bodies and organizations that operate within the public health domain recognize the diversity of multicultural populations and serve all people and all communities.

***The outcomes:*** SFBC and MC could complement each other to enhance positive counselling outcomes. SFBC is goal-oriented, facilitating behavioural change in the present, and making a difference in the future. With MC, clients' cultural identity is validated, counsellors' cultural competence is highlighted, improvement of intercultural communication is encouraged, and strengthening the therapeutic relationship is emphasized. Both SFBC and MC acknowledge the power of language in meaning making (De Jong & Berg, 2002) and cross-cultural communication (Sue & Sue, 2008), emphasizing that counsellors need to purposely choose language to express positive and respectful messages. Furthermore, MC also encourages counsellors to use drawing or other kinds of metaphors when a language barrier is encountered.

***The key differences:*** The key differences in SFBC and MC are the time frame. For SFBC, historical problems are not at the center of the counselling work, while MC counsellors view historical and current social and political issues as an important part of counselling work, addressing issues concerning clients, such as historical oppressive experiences in relation to their current struggles, the impact of colonization or institutional racism they have encountered, and advocating for their clients. Another difference between these two models is that SFBC focuses on a specific and concrete goal that clients want to achieve, and MC takes a holistic and context-dependent approach, including the clients' levels of development of cultural identity, the process of acculturation, experiences of general, culture-specific, and unique individual areas (Sue & Sundberg, 1996).

Despite their differences, SFBC and MC could be compatible because both value and respect clients' worldviews, treat clients as experts in their situations, validate clients own conceptualization of their presenting problems and solutions, and building a positive and working therapeutic relationship.

## Rationale for the study

### Selecting treatments

CBT and MI are preferred research-based approaches for treating pathological or problem gambling. Alternative treatments for problem or pathological gambling have been rarely reported in terms of empirical studies. Little is known about SFBC and combining SFBC and MC for problem or pathological gambling in culturally diverse clients.

There is a need for the development of alternative and culturally appropriate approaches that are supported empirically and clinically to treat problem or pathological gambling for the following reasons: 1) alternatives can offer more treatment options to clients who do not respond well to CBT or MI; 2) a brief and strength-based alternative treatment, such as SFBC, is more affordable in the current tight health funding situations, as well as being suitable and practical for clients with chronic and multiple problem (this is often the case with problem or pathological gambling clients); 3) given the increase in problem or pathological gambling in Pakeha, Maori, Pacific Islander, and Asian populations in the last two decades in New Zealand society (Department Internal Affair New Zealand, 2009), combining alternatives with a culture-centered approach would be appropriate to this growing multicultural clientele; 4) because a high rate of premature termination often occurs among culturally diverse clients who use mainstream services (Sue & Sue, 2008).

Therefore, there is a need to develop alternative treatments for engaging with and reaching out to these clients, helping them complete the counselling process, and maintaining treatment progress. Considering the above reasons, the current study has selected the SFBC and SFBC+MC as alternative treatments for problem or pathological gambling.

## Studying acceptability of treatments

The study of the acceptability of alternative treatments is one dimension for evaluating empirically supported treatment procedures and outcomes in the real world by potential service users. Treatment acceptability refers to the *appropriateness*, *fairness*, and *reasonableness* of the treatment procedures as judged by the potential consumers (Kazdin, 1980a, 1980b, 1981). To date, there is no study on the acceptability of alternative treatments for problem or pathological gambling in culturally diverse clients. The present study will add to knowledge in this area.

The primary purpose of this study was to examine the acceptability of SFBC and SFBC+MC as treatment alternatives for clients with problem or pathological gambling. The comparison group was CBT and MI for problem or pathological gambling in male and female Pakeha clients, because CBT and MI have been the most researched and have become the treatment of choice in the problem or pathological gambling treatment field to Western clients.

The uniqueness of SFBC is in the core assumption that a solution can be found without the burden of gaining insight into and understanding the nature of presenting problems. If the acceptability rates of SFBC and SFBC+MC were similar to the acceptability rates of CBT and MI, this information would suggest the process of implementation of these alternatives would be less difficult, and counselling providers might recommend or introduce them to their clients. In addition, when the providers choose the most acceptable alternative, they are likely to carry them out more devotedly and confidently, which may lead to better treatment outcomes.

The second goal of this study was to investigate the acceptability of treatments across culturally diverse clients described in the vignette case examples. If low rates of acceptability of treatments were found in non-Western clients but not in Western

clients, this information might be helpful to understand a part of the problem regarding the high rates of premature termination among non-Western clients.

Alongside the acceptability of SFBC and SFBC+MC, an additional purpose of this study was to gain information on the evaluation of the cultural competence of counsellors described in the vignette case. This is because the counsellor's ability to operate in a multicultural counselling context can influence the quality of the counsellor-client relationship, and have an impact on the counselling processes and outcomes (Sue, Arredondo, & McDavis, 1992; Sue & Sue, 2008).

Counselling service providers were chosen as research respondents because they would be the primary treatment providers, thus, their feedback on the acceptability was useful to guide treatment selection, professional training, and clinical practicability. If the respondent counsellors rate a low level of preference for SFBC and/or SFBC+MC for problem or pathological gambling, they may be less likely to choose them in their clinical practice. As a result, SFBC and SFBC+MC might have little chance of being implemented in actual clinical practice, and have limited input on the effectiveness of the treatment outcome of problem or pathological gambling.

The vignette case examples were used instead of real clients because the local services for treating problem or pathological gambling were not accessible to the researchers. There were sixteen vignette examples, and the clients were female, male Pakeha, Maori, and Asian. Pacific Islanders were not included, owing to the scope of this thesis, and this was a limitation in this study design.

## Hypotheses

We were interested in acceptability differences as rated by counsellors between treatment conditions and clients' cultural ethnicities and gender. It was predicted that:

1) The acceptability rates of SFBC and SFBC+MC would be no different from CBT and MI
2) All four treatment conditions, SFBC, SFBC+MC, CBT, MI would not be rated differently as a function of the clients' gender
3) Acceptability rates would be different across clients' ethnicities: Pakeha, Maori, Asian
    a. The rates of acceptability of SFBC, SFBC+MC, CBT, and MI for Pakeha clients would be no different
    b. The rates of acceptability of SFBC+MC would be higher than SFBC, for Maori and Asian clients

# Method

## Survey Construction

The survry material sent to potential counsellor respondents included the information sheet, a respondent demographic questionnaire (including cultural training/experiences questionnaire), one of sixteen vignette case examples, two Likert rating scales, namely the Treatment Evaluation Inventory (15 questionnaires, 7-point) and the Cross Cultural Counselling Inventory-Revised (20 questionnaires, 5-point), and a postage paid addressed return envelope. The survey was in pencil-and-paper format.

The information sheet is shown in Appendix A. The information sheet explained the purpose of the study, provided information for data confidentiality and respondents' right to stop participating, indicated that the study was reviewed by the University of Canterbury Ethic Committee, and provided contact details of key contact persons-two research supervisors and the research student.

The respondent demographic questionnaire is shown in Appendix B. The demographic questionnaires included respondents' gender, age, ethnicity, language, counselling training, the length of counselling practice in general and/or in problem gambling field, bicultural and diverse cultural training and experiences.

There were sixteen vignette case examples in the study. Each case example included one counsellor, one client with problem or pathological gambling, one selected treatment condition, one gender and one ethnicity of the client. Each case example started with a description of a client with problem or pathological gambling issue, followed by a brief introduction of key components of intervention of the selected treatment condition, and then provided a description of the treatment process

and outcome. The code of the sixteen case examples client is shown in the Table 1 below.

**Table 1. The code of the sixteen vignette case examples**

| **Ethnicities** | **Pakeha** | | **Maori** | | **Asian** | |
|---|---|---|---|---|---|---|
| **Gender** | **Male** | **Female** | **Male** | **Female** | **Male** | **Female** |
| **Code** | **The four treatment conditions** | | | | | |
| Scenario 1 | SFBC[a] | | | | | |
| Scenario 3 | | SFBC | | | | |
| Scenario 5 | | | SFBC | | | |
| Scenario 7 | | | | SFBC | | |
| Scenario 9 | | | | | SFBC | |
| Scenario 11 | | | | | | SFBC |
| Scenario 2 | SFBC+MC[b] | | | | | |
| Scenario 4 | | SFBC+MC | | | | |
| Scenario 6 | | | SFBC+MC | | | |
| Scenario 8 | | | | SFBC+MC | | |
| Scenario 10 | | | | | SFBC+MC | |
| Scenario 12 | | | | | | SFBC+MC |
| Scenario 13 | CBT[c] | | | | | |
| Scenario 14 | | CBT | | | | |
| Scenario 15 | MI[d] | | | | | |
| Scenario 16 | | MI | | | | |

a. SFBC: Solution-Focused Brief counselling
b. SFBC+MC: Solution-Focused Brief counselling+Multicultural Counselling
c. CBT: Cognitive-Behavioural Therapy
d. MI: Motivational Interviewing

The respondents were asked to read the vignette case example first, and then filled in two measurement questionnaires. The first measurement was *Problem Gambling Treatment Evaluation Inventory*, a 15-item questionnaires measured by a 7-point Likert rating scales. The problem or pathological gambling-TEI was modified from Kazdin's original TEI version (Kazdin, 1980a, 1980b, 1981). The TEI was for assessing acceptability of treatments.

The second measurement was *Cross-Cultural Counselling Inventory-Revised* (CCCI-R), a 20-item questionnaires measured by a 5-point Likert rating scales (LaFromboise, Coleman, & Hernandez, 1991). The CCCI-R was for accessing the cultural competency of counsellors who were depicted in the vignette case examples.

There was blank space on both inventories for respondents to write any comments if they wished to. These two inventories are shown in Appendix C

## Respondent recruitment

Between June 2009 and January 2010, three hundred and thirty-one survey packs were distributed to potential counsellor respondents in New Zealand and 97 packs were returned. The return rate was 29.31%. In June 2009, 192 survey packs were given out to potential counsellor respondents by post or by being physically delivered. These respondents were found through the Christchurch Yellow Pages, the NZ Search webpage, New Zealand Association of Christian Counsellors' webpage, the New Zealand Association of Psychotherapists' webpage, the directory of the New Zealand Association of Counsellors (NZAC), and counselling services and training providers personally known to the research student in South Island regions. Forty-eight completed survey packs were returned.

In August 2009, 102 survey packs were given out through the post or by being physically delivered. These potential counsellor respondents were found through counselling services and training providers whom the research student had known in the South Island regions. Twenty-seven packs were returned.

In October 2009, the research student approached NZAC to put an advertisement on its North Island email network. The advertisement was circulated to 1325 NZAC members in the North Island. Thirty-four people responded and agreed to participate in the survey. Thirty-four packs were mailed out. An additional 7 packs were mailed out to two counselling agencies in Christchurch as the research student approached them. Twenty-one packs were returned.

## Data Analysis Procedure

Each respondent's scores from the TEI and CCCI-R were entered in to Excel, along with the respondent's demographic data. Then all scores were transferred to PASW 18.0 for further analysis. Analysis of variance (ANOVA) was used to test the research hypotheses, comparing mean differences in acceptability of different counselling scenarios. ANOVA was also used to investigate differences among respondents' demographic variables, such as gender, ethnicity, age, education, length of counselling practice, and experiences of Maori culture, and diverse culture.

# Results

## The questionaires

Ten of the 97 respondents did not complete the *Treatment Evolution Inventory* (TEI) questionnaires and 9 did not complete the *Cross Cultural Counselling Inventory-Revised* (CCCI-R) questionnaires. These missing data packs were excluded from the data pool. The detailed numbers of expected returned survey packs, distributed packs, and returned packs in each treatment condition are in Table 2 and Table 3 as below.

**Table 2**
**The numbers of expected, distributed, and returned survey packs for CBT and MI treatment conditions for Pakeha clients in the vignette case examples**

| | CBT | | | MI | | |
|---|---|---|---|---|---|---|
| | Expected | Distributed | Returned | Expected | Distributed | Returned |
| Male | 10 | 14 | 4 | 10 | 14 | 6 |
| Female | 10 | 14 | 5** | 10 | 14 | 5 |
| Total | | | 7 | | | 11 |

** includes two packs with missing data
The total is the number of returned survey packs for both female and male without the missing data packs

**Table 3**
**The numbers of expected, distributed, and returned survey packs for SFBC and SFBC+MC treatment conditions for Pakeha, Maori, and Asian clients in the vignette case examples**

| | SFBC | | | SFBC+MC | | |
|---|---|---|---|---|---|---|
| | Expected | Distributed | Returned | Expected | Distributed | Returned |
| Pakeha | | | | | | |
| Male | 10 | 23 | 5 | 10 | 23 | 5 |
| Female | 10 | 25 | 4 | 10 | 23 | 10* |
| Total | | | 9 | | | 14 |
| Maori | | | | | | |
| Male | 10 | 23 | 8*** | 10 | 22 | 7 |
| Female | 10 | 22 | 6 | 10 | 26 | 4 |
| Total | | | 11 | | | 11 |
| Asian | | | | | | |
| Male | 10 | 22 | 5* | 10 | 22 | 7* |
| Female | 10 | 22 | 6* | 10 | 22 | 10* |
| Total | | | 9 | | | 15 |

* Includes one pack with missing data
***Includes three packs with missing data
The total is the number of returned survey packs for both female and male excluded the missing data packs

The purpose of this project was to compare the treatment acceptability ratings of counsellors to vignette case examples of different counselling scenarios across four treatment conditions, three ethnicities, and two genders. In the initial design of this study, two matrixes were chosen to test for all the dependent variables including the TEI and the CCCI-R scores for genders, ethnicities, and treatment conditions. The first matrix included a 2x2x3 (2 treatments/SFBC and SFBC+MC x 2 genders/male and female x 3 ethnicities/Pakeha, Maori, Asian). The second was a 2x2 (2 treatments/CBT and MI x 2 genders/Pakeha male and Pakeha female) that was treated as a control group. Analysis of variance (ANOVA) was used to verify the group mean differences in acceptability.

However we could not get the sample size we expected in each condition, so in order to increase the sample size, the study design was revised. Since there were no significant differences by gender across all treatment conditions and ethnicities, two

gender variables were combined into one. The first matrix became 2x3 (2 treatment conditions x 3 ethnicities). The second matrix became 2 treatment conditions. The sample size was the total number in each treatment condition and each ethnicity shown in the above Table 2 and Table 3.

## Reliability statistics

The data of the TEI and the CCCI-R questionnaires was analysed and the Cronbach's Alpha of the TEI was $\alpha$= .959; standardized items $\alpha$=.959; and the Cronbach's Alpha of the CCCI-R was $\alpha$=.951; standardized items $\alpha$=.950. The results indicated that both the TEI and CCCI-R met the criteria of reliability.

In the 97 survey packs returned, the valid number of cases was 87 for the TEI questionnaires (10/97 with data missing were excluded); the valid number of cases for the CCCI-R questionnaires was 88 (9/ 97 with missing data were excluded).

## Hypotheses verification

The dependent variables were mean scores on TEI and CCCI-R questionnaires across three ethnicities and four treatment conditions; the independent variables were four treatment modalities: SFBC, SFBC+MC, CBT, MI; three ethnicities of the clients in sixteen vignette case examples: Pakeha, Maori, Asian, and two genders of the clients in each vignette case example: male, female.

Hypothesis 1: The acceptability rates of SFBC and SFBC+MC would not differ significantly from CBT and MI for Pakeha clients. The results revealed that the acceptability ratings of the first three treatment conditions (SFBC, SFBC+MC, CBT) did not differ significantly, and the rating on the MI condition was significantly lower.

Hypothesis 2: The acceptability rates of all four treatment conditions, SFBC, SFBC+MC, CBT, MI would not differ significantly in terms of the client's gender. The results supported this hypothesis.

Hypothesis 3: The acceptability rates of SFBC and SFBC+MC will differ significantly depending on client ethnicities. The ANOVA analysis on TEI scores revealed the main effects of treatment conditions, $F$ (3, 15)=3.929, $p$= .011 and ethnicities, $F$ (2, 15)=2.244, $p$=< .113, and the interaction effect of treatment conditions and ethnicities, $F$ (2, 15)=5.525, $p$ < .006. These results indicated that perceived treatment acceptability varied across treatment procedures, clients' ethnicities, and the interaction between these two variables. This finding supported Hypothesis 3.

The main effects of treatment conditions, $F$ (3, 15)=8.740, $p$= .000 and ethnicities, $F$ (2, 15)=2.507, $p$= .088 and the interaction effect of treatment conditions and ethnicities, $F$ (2, 15)=3.952, $p$= .023, also were revealed in CCCI-R scores. The results indicated that the cross cultural counselling competency of the counsellors in the vignette case examples was perceived as varying across treatment conditions and ethnicities of the clients, as well as the interaction of the two variables.

## Respondent demographic data

The respondent demographic data showed that Pakeha and other Europeans were the majority (89.9%) of counsellor respondents in this sample compared to Maori (7.2%) respondents and another two ethnicities (1% for each ethnicity). In addition, the demographic characteristics also showed a higher percentage of female respondents than male respondents, more were mono-lingual than bilingual or multilingual, and middle-aged rather than aged under forty. The data might suggest

that Westerners, female, monolingual, and middle-aged are the mainstream of the counselling workforce in New Zealand society. Demographic attributes of the respondents are shown in Table 4 as below.

**Table 4**
**Demogranphic characteristics of the respondents**

| | | | |
|---|---|---|---|
| **Gender** | | **Language** | |
| Female | 67% | English | 97.9% |
| Male | 27.8% | Bilingual or Multilingual | 7.4% |
| Missing | 5.2% | Missing | 2.1% |
| **Ethnicity** | | **Age** | |
| Pakeha | 74.2% | 51-60+ | 35.1% |
| European | 15.5% | 41-50 | 23.7% |
| Maori[b] | 7.2% | 31-40 | 5.2% |
| Aboriginal[a] | 1% | 20-30 | 3.1% |
| Asian[c] | 1% | Missing[d] | 16.5% |
| Missing | 1% | | |

a. Australian Aboriginal
b. Maori population is 14/.6% in New Zealand, and 7.2% in Canterbury region
c. Asian population is 9.2% in New Zealand, and 5.6% in Canterbury region (Statistic New Zealand, 2006 Census)
d. The Age category has the highest percentage of missing data compared to all other categories

The counsellor respondents were also asked about their bicultural and diverse cultural training and experiences. The data about bicultural and diverse cultural involvement showed that the majority of counsellor respondents had received Treaty of Waitangi training (89.7%). The range of other bicultural training activities the respondents had received was from 50.5% to 29.9%. The range of diverse cultural activities the respondents reported was from 34% to 14.4%. Features of counsellor respondents' culturally relevant training experiences are shown in Table 5 as below.

**Table 5**
**Bicultural and diverse cultural training and experiences**

| Bicultural training | | | Diverse cultural training | | |
|---|---|---|---|---|---|
| The Treaty of Waitangi | 87 | 89.7% | | | |
| Marae-based | 65 | 30.9% | Cultural studies | 32 | 33% |
| Te Reo | 49 | 50.5% | Non-English course | 23 | 23.7% |
| Supervision | 39 | 40.2% | Supervision | 14 | 14.4% |
| Program | 29 | 29.9% | Workshop | 33 | 34% |
| | | | Research | 14 | 14.4% |
| Others | 7 | 7.2% | Others | 2 | 2.1% |

The data showed that the counsellor respondents overall were involved with bicultural activities much more than diverse culture. In the New Zealand context, bicultural counselling work has a focus on working with the Maori population. Some findings in the present study could be looked at in this biculturally oriented context. For example, we found that the counsellor respondents prefered the culture-centred counselling (SFBC+MC) for Maori clients in the vignette case examples, and this was not the case for the Asian clients.

## The treatment acceptability ratings: Treatment Evaluation Inventory (TEI) results

The ratings of counsellor respondents for acceptability showed significant main effects for the four treatment conditions and the three ethnicities, and significant interaction effect for treatmentd and ethnicities.

The main effect of the four treatment conditons was significant, $F$ (3, 15)=3.939, $p$=.011, as shown in Table 6 below.

**Table 6**
**Dependent variable: Acceptability under the four treatment conditions**

| | | | 95% Confidence Interval | |
|---|---|---|---|---|
| Treatment | Mean | Std. Error | Lower Bound | Upper Bound |
| SFBC | 67.899 | 3.244 | 61.443 | 74.355 |
| SFBC+MC | 76.170 | 2.774 | 70.649 | 81.691 |
| CBT | 76.429[a] | 6.572 | 63.346 | 89.511 |
| MI | 61.091[a] | 5.243 | 50.655 | 71.527 |

a. Based on a modified population marginal mean

Of the treatments, Solution-Focused Brief Counselling plus Multicultural Counselling (SFBC+MC) was the most acceptable treatment for all clients in the vignette case examples, and SFBC was the least acceptable. For the control group, Cognitive-Behavioural Therapy (CBT) was the most acceptable treatment, and Motivational Interviewing (MI) was the least. To compare the treatment group to the control group, SFBC+MC was equally as acceptable as CBT and was significantly more acceptable than MI. SFBC was less acceptable than CBT but was more acceptable than MI.

There was a significant main effect of ethnicities, $F$ (2, 15) =2.244, $p$=.113, as shown in Table 7 below.

**Table 7**
**Acceptability across the three ethnicities**

| | | | 95% Confidence Interval | |
|---|---|---|---|---|
| (Clients) Ethnicities | Mean | Std. Error | Lower Bound | Upper Bound |
| Pakeha | 73.429 | 2.805 | 67.846 | 79.013 |
| Maori | 67.182[a] | 3.707 | 59.803 | 74.561 |
| Asian | 70.822[a] | 3.666 | 63.525 | 78.119 |

a. Based on a modified population marginal mean.

Independent of the treatment received, treatment was rated as most acceptable for Pakeha clients in the vignette case examples, followed by Asian clients, with the lowest level acceptability found for Maori clients.

When the treatment received was taken into account, a significant interaction effect was revealed between treatment conditions and clients' ethnicities, $F$ (2, 15) =5.525, $p$=.006. SFBC+MC was the most acceptable treatment for Maori clients, followed by Pakeha, and the least acceptable for Asian clients. SFBC was the most acceptable treatment for Pakeha, followed by Asian, and the least for Maori. SFBC for Maori clients had the lowest mean scores among the four treatment conditions across the three ethnicities while SFBC+MC had the highest mean scores among the four treatment conditions across the three ethnicities.

There were increasing mean scores with a decreasing standard deviation for Maori clients, a similar direction was found for the Pakeha, and a reverse one for the Asian. The summary of mean acceptability, standard deviations, and sample size is shown in Table 8 and the summary of acceptability of means is shown in Figure 1 below.

**Table 8**
**Problem Gambling Treatment Evaluation Inventory(TEI) ratings: Means(M), Standard Deviations(SD), and sample size(N) for each of the treatment conditions across the three ethnicities**

| Treatment condition | | Maori | N | Pakeha | N | Asian | N | Marginal Means | N |
|---|---|---|---|---|---|---|---|---|---|
| SFBC | | | | | | | | | |
| | M | 53.36 | 11 | 76.56 | 9 | 73.78 | 9 | 66.9 | 29 |
| | SD | 18.57 | | 12.49 | | 21.83 | | 20.52 | |
| SFBC+MC | | | | | | | | | |
| | M | 81 | 11 | 79.64 | 14 | 67.87 | 15 | 75.6 | 40 |
| | SD | 16.87 | | 15.38 | | 13.91 | | 16.07 | |
| CBT | | | | | | | | | |
| | M | | | 76.43 | 7 | | | 76.43 | 7 |
| | SD | | | 14.04 | | | | 14.04 | |
| MI | | | | | | | | | |
| | M | | | 61.09 | 11 | | | 61.09 | 11 |
| | SD | | | 23.58 | | | | 23.58 | |
| Total | | | | | | | | | |
| | M | 67.18 | 22 | 73.43 | 41 | 70.08 | 24 | | |
| | SD | 22.36 | | 18.33 | | 17.09 | | | |
| | | | | | | | **GM** | 70.93 | |
| | | | | | | | | 19.06 | 87 |

The range of the standard total TEI scores was from 15, the lowest, to 105, the highest

## Figure 1

**Problem Gambling Treatment Evaluation Inventory(TEI) mean ratings for the four treatment conditions across the three ethnicities**

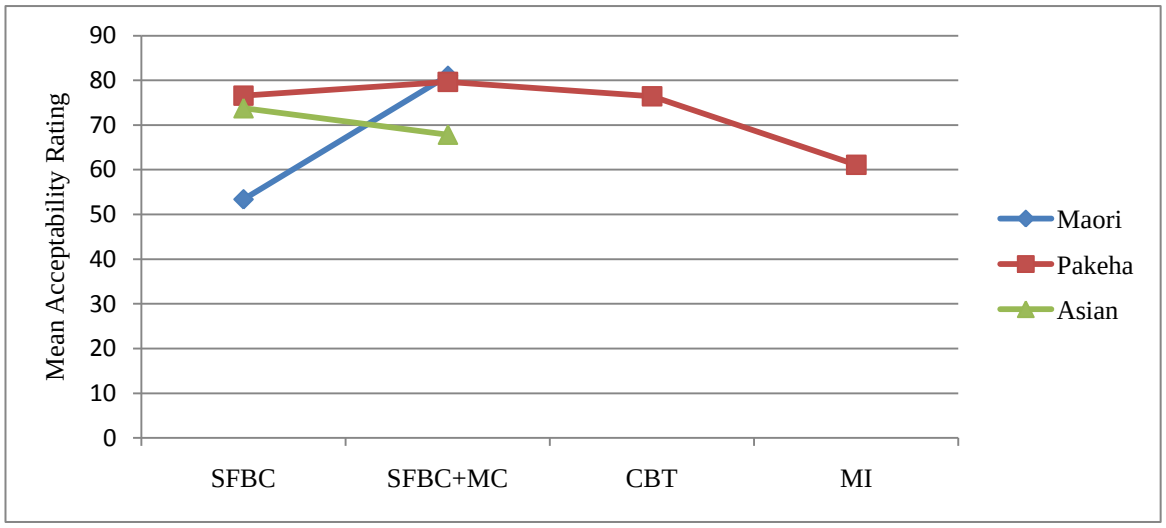



**Figure 1**: Mean acceptability ratings for TEI for each of the four treatment conditions across the three ethnicities

It is shown in Figure 1 that acceptability levels of SFBC for both Pakeha and Asian were similar, indicating that, in the view of counsellors, the general counselling modality that was developed in the West might be as acceptable to Asians as it is to Pakeha. The levels of acceptability of SFBC+MC for both Maori and Pakeha were similar, so it could mean that culture-centred counselling is judged as more acceptable to both Westerners and Maori clients. Levels of the acceptability of SFBC, SFBC+MC, and CBT were close to those of Pakeha clients. Since SFBC to Maori clients had the lowest level of acceptability among the four treatment conditions across the three ethnicities, it would be more culturally appropriate for Maori clients to be counselled with a culturally modified general counselling modality.

## The ratings of Cross Cultural Counselling Inventory-Revised (CCCI-R) results

The counsellor respondents were asked to evaluate the levels of the cross cultural counselling competency of the counsellors in the vignette case examples. The CCCI-R was used for this task. The significant main effects for the four treatment conditions and the three ethnicities of the clients were revealed, and an interaction effect showed between treatment and client ethnicity.

The main effects of treatment conditions, $F$ (3, 15)=8,74, $p$= .001, of client ethnicities, $F$ (2, 15) =2.51, $p$ < .088, and an interaction effect, $F$(2, 15)=3.95, $p$ < .023, indicated that the ratings of the cross cultural counselling competency of the counsellors in the vignette case examples varied across the treatment procedures and clients' ethnicities. The data is shown in Table 9 and Table 10 below.

**Table 9**
**The ratings of the cross cultural competency of the counsellors in the vignette case examples: CCCI-R scores on four the treatment conditions**

| | | | 95% Confidence Interval | |
|---|---|---|---|---|
| Treatment | Mean | Std. Error | Lower Bound | Upper Bound |
| SFBC | 61.783 | 2.500 | 56.808 | 66.759 |
| SFBC+MC | 75.634 | 2.184 | 71.289 | 79.980 |
| CBT | 72.889[a] | 4.550 | 63.834 | 81.943 |
| MI | 58.000[a] | 4.826 | 48.396 | 67.604 |

a. Based on a modified population marginal mean

**Table 10**
**The ratings of the cross cultural competency of the counsellors in the vignette case examples: CCCI-R scores on the three client ethnicities**

| | | | 95% Confidence Interval | |
|---|---|---|---|---|
| (Clients) Ethnicities | Mean | Std. Error | Lower Bound | Upper Bound |
| Pakeha | 69.083 | 2.258 | 64.588 | 73.577 |
| Maori | 69.636[a] | 2.796 | 64.072 | 75.200 |
| Asian | 63.769[a] | 2.751 | 58.294 | 69.244 |

a. Based on a modified population marginal mean.

Overall, the respondents rated the counsellors in the vignette case example with higher scores across the three ethnicities under the SFBC+MC condition than the

SFBC condition. The variations between the means of SFBC+MC and SFBC conditions were much greater for the Maori and the Asian than for the Pakeha. There were an increasing mean scores with decreasing standard deviation for SFBC+MC and SFBC conditions across the three ethnicities. The highest score was SFBC+MC for Maori, the lowest was SFBC for the Asian. The data is shown in Table 11 and Figure 2 below.

**Table 2**

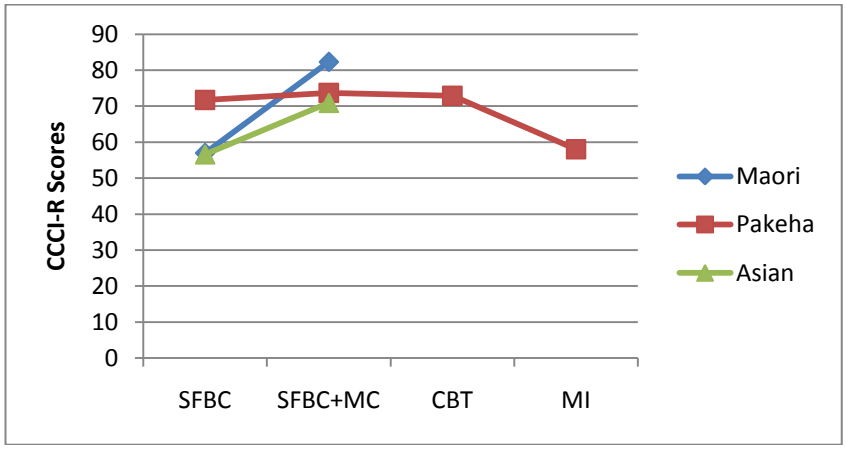
**The ratings of the cross cultural competency of the counsellors in the vignete case examples: CCCI-R scores of Means(M), Standard Deviation(SD), sample size (N) on the four treatment conditions and the three client ethnicities**

| Treatment | Maori | N | Pakeha | N | Asian | N | Marginal Means | N |
|---|---|---|---|---|---|---|---|---|
| SFBC | | | | | | | | |
| M | 57 | 13 | 71.75 | 8 | 56.6 | 10 | 60.68 | 31 |
| SD | 15.89 | | 14.78 | | 14.66 | | 16.14 | |
| SFBC+MC | | | | | | | | |
| M | 82.27 | 11 | 73.69 | 13 | 70.94 | 16 | 74.95 | |
| SD | 7.14 | | 13.43 | | 10.73 | | 11.62 | 40 |
| CBT | | | | | | | | |
| M | | | 72.89 | 9 | | | 72.89 | 9 |
| SD | | | 13.67 | | | | 13.67 | |
| MI | | | | | | | | |
| M | | | 58 | 8 | | | 58 | |
| SD | | | 18.96 | | | | 18.96 | 8 |
| Total | | | | | | | | |
| M | 68.58 | 24 | 69.79 | 38 | 65.42 | 26 | | |
| SD | 17.87 | | 15.71 | | 14.04 | | | |
| | | | | | | GM | 68.17 | |
| | | | | | | | 15.79 | 88 |

The range of the total of CCCI-R scores was from 20 (the lowest) to 100 (the hightest)

## Figure 2

**The means of the cross cultural competency of the counsellors in the vignete case examples: CCCI-R scores on four treatment conditions and three client ethnicities**




## Discussion

This study aimed at gaining knowledge of the acceptability of alternative counselling treatments, SFBC and SFBC+MC, to problem or pathological gambling clients in contemporary New Zealand multicultural society where the Treaty of Waitangi is a foundational constitutional document. Originally, the research design of this study required 160 counsellor respondents to cover all the vignette case examples in the design, however, we were unable to get the numbers we needed. Because of the small sample size, when treatment-ethnicity was tested, we combined the two genders in order to increase the sample numbers. On the whole, the small sample size can still provide some useful understanding of the acceptability of alternative treatments for problem or pathological gambling, but does limit conclusions.

Hypothesis 1: The acceptability rates of SFBC and SFBC+MC would not differ significantly from CBT and MI for Pakeha clients.

The results supported this hypothesis, in that the acceptability of SFBC and SFBC+MC was not different from CBT but was significantly higher than MI. For Pakeha clients, SFBC+MC, SFBC, and CBT fell in high-medium range mean scores with a low degree of variation compared to MI's mean scores in the low-medium range with a high degree of variation.

These results indicated that the counsellor respondents have agreed on SFBC+MC, SFBC and CBT as more acceptable treatments for Pakeha clients with problem or pathological gambling in the vignette case examples, they had a low preference for MI and showed a high level of disagreement about it. It suggests that more counsellor respondents would be likely to consider, select, and recommend SFBC+MC or SFBC to Pakeha clients with problem or pathological gambling clients, but they might approach MI quite differently. Furthermore, it would be reasonable to think that the counsellor respondents might also choose SFBC+MC or SFBC for other issues closely related to problem or pathological gambling, such as family relationship distress, domestic violence, marital discord, child neglected or abuse, financial loss, fraudulent criminal acts, alcohol abuse and substance dependency, depression and anxiety, and suicide. As there has been no other study of the acceptability of SFBC and SFBC+MC for problem or pathological gambling, we lacked information to compare with and expand our understanding of it.

Hypothesis 2: <u>The acceptability rates of all four treatment conditions, SFBC, SFBC+MC, CBT, MI would not differ significantly in terms of the client's gender.</u>

As was predicted, significant differences in the acceptability rates of the four treatment conditions according to client's gender were not found. These results suggested that client gender could have less influence on the way the counsellor respondents evaluated the acceptability of the treatment conditions. This could

because that they would not view problem or pathological gambling as a gender-related problem, such as the case of postnatal-depression or intimate partner violence. The small sample size might be not sufficient to test significant gender effects across the treatment conditions.

Hypothesis 3: The acceptability rates of SFBC and SFBC+MC will differ significantly depending on client ethnicities

**Pakeha clients** in the vignette case examples

It was predicted that the acceptability rates of SFBC and SFBC+MC would not differ significantly for Pakeha clients in the vignette case example. We found that SFBC+MC was slightly more accepted than SFBC. All vignette case examples of this study were cross-cultural in terms of ethnic origin between counsellors and clients. We did not have an ethnic-matched counsellor-client group to compare to owing to the scope of this study. However, these results suggested that SFBC+MC and SFBC would be acceptable in the cross-cultural counselling condition, but SFBC+MC was the more acceptable one. The results suggested that the cultural needs of Pakeha clients would become recognized when non-Pakeha counsellors were the service providers. Traditionally, cross-cultural counselling talks about Western professionals working with minority ethnic clients; the reverse is a rare case which has received little attention in the field. Never-the-less, as more non-Pakeha counsellor enter the workforce, it will become a new salient issue, and deserves investigation

*Maori* and *Asian* clients

It was predicted that the rating scores of the acceptability of SFBC would be lower than SFBC+MC in Maori and Asian clients in the vignette case examples. We

found the results supported the prediction in regard to Maori clients, but was the opposite in Asian clients.

**Maori clients** in the vignette case examples

SFBC+MC was rated as much more acceptable than SFBC for Maori clients. The mean score of SFBC+MC was high with a low degree of variation, and the mean score of SFBC was low with a high degree of variation. The results indicated that the majority of the counsellor respondents agreed that SFBC+MC was highly acceptable for Maori clients with problem or pathological gambling. In contrast, SFBC for Maori clients was much less acceptable, and the counsellor respondents had a high level of disagreement of it, note, that this is not a context effect. Counsellor respondents received only one vignette case example to rate, so they were not influenced by accruement knowledge of alternative treatment while making their ratings, The results suggested that Maori clients' cultural needs in cross-cultural counselling were perceived as highly identified and validated, and SFBC+MC would be better received and accepted by counsellors than SFBC. In addition, the process of implementation of SFBC+MC would be likely to meet with fewer barriers and less resistance for counsellors.

**Asian clients** in the vignette case examples

The results were the opposite from what we expected. SFBC was rated as more acceptable than SFBC+MC for Asian clients with problem or pathological gambling in the vignette case examples. The mean scores of SFBC for Asian clients were high with a high degree of variation of SFBC, and the mean scores of SFBC+MC for Asian clients was low with less variation. This indicated that SFBC for the Asian clients was more acceptable by the counsellor respondents, but they had more

disagreement in their opinions of it. In contrast, the counsellor respondents consistently agreed that SFBC+MC for Asian clients was less acceptable. The results suggested that the counsellor respondents might see SFBC as a more acceptable counselling modality for Asian clients with problem or pathological gambling, but they might have different views about the implementation of it. The majority of counsellor respondents agreed that they would be less likely to select SFBC+MC for Asian clients with problem or pathological gambling. There might be more barriers and counsellor resistance if SFBC+MC for the Asian clients was introduced. The results could suggest that cultural needs of Asian clients in the vignette case examples were not viewed as being important by the counsellor respondents, SFBC would be well acceptable by counsellor respondents for Asian clients, and SFBC+MC would be less acceptable.

Overall, we have found significant differences in the acceptability rates across clients' ethnicity and treatment conditions.

**Measurement 1: Treatment Evaluation Inventory (TEI)**

1) Four treatment comparison: SFBC+MC was perceived by counsellor respondents as the most acceptable treatment for Pakeha clients in the vignette case examples, followed by SFBC, then CBT, and MI was the least. 2) Three ethnicities comparison: SFBC+MC was perceived by counsellor respondents as the most acceptable treatment for Maori clients with problem or pathological gambling in the vignette case examples and the least acceptable for Asian clients. 3) SFBC was perceived by counsellor respondents as the most acceptable treatment for Pakeha clients with problem or pathological gambling in the vignette case examples, and the least for Maori clients.

**Measurement 2: Cross Cultural Counselling Inventory-Revised**

The inventory was used to evaluate perceived overall cross-cultural competence of counsellors depicted in the vignette case examples. SFBC+MC had the highest rating scores across all ethnicities and treatment conditions. When the counsellor was depicted as working with Maori clients in the SFBC+MC condition, the highest mean competence score with a lowest degree of variation was observed, followed by Pakeha, then Asian clients in the vignette case examples. Counsellors working with Pakeha clients in the SFBC condition had the highest mean competence scores, followed by Maori clients, and Asian clients had the lowest mean score. This SFBC mean score for Asian clients was also the lowest mean score across three ethnicities and four treatment conditions. The results suggested that counsellors depicted in SFBC+MC condition were viewed as the most culturally competent for Maori, followed by Pakeha, and Asian clients in the vignette case examples, and the counsellors in SFBC condition were the least culturally competent for Asian clients, followed by Maori, and Pakeha clients in the vignette case examples.

Given the same SFBC+MC conditions for all three ethnic groups, i.e, Pakeha, Maori, and Asian clients in the vignette case examples, the counsellor respondents largely agreed that SFBC+MC approach would be a better treatment of choice for Maori clients as measured by counselling competence. Additionally, the SFBC+MC approach was viewed as being acceptable to Pakeha clients in an intercultural setting, which was supported from a multicultural perspective, although little research has been done in the case of minority ethnic professionals working with Western clients in Western countries. The finding was consistent with substantial multicultural research conducted in Western countries in terms of delivering culture-centered

counselling approach (SFBC+MC) for Maori and Pakeha clients in a cross-cultural counselling setting.

The finding that SFBC+MC approach was rated as less acceptable to Asian clients was inconsistent with multicultural counselling research published in the last four decades, especially from North American and European academic scholars and educators, clinical researches, and practitioners. Asian's rich cultures and long civilization history have a powerful influence on Asian people's worldviews and their cultural identity formation and development. Because of this, we might assume that Asian clients would need a culture-centered treatment mode more than a general treatment. For example, a number of studies support delivering CBT integrated with the Chinese cultural worldview to Chinese populations (Chen & Davenport, 2005; Foo & Kazantzis, 2007; Hodges & Oei, 2007; Hwang, Wood, Lin, & Cheung, 2006; Lin, 2001).

In the present study, based on the first measurement (TEI), counsellor respondents rated the SFBC+MC condition was least acceptable than the SFBC conditions for Asian clients in the vignette case examples. Based on the second measurement (CCCI-R), the respondents rated counsellors depicted in the SFBC+MC condition as being more culturally competent than the counsellors depicted in the SFBC conditions for the Asian clients. In another words, a culture-centered approach for Asian clients was viewed as less acceptable, but the counsellors depicted in the vignettes delivered this culture-centered approach were viewed as being more culturally competent. This finding appears that a combined culture-centred approach and more culturally competent counsellors depicted can be a less desirable package for Asian clients in the vignette case examples. This is a puzzling picture to the researchers in this study.

Based on the results of this study, it seems that the culture factor in cross-counselling work was rated by counsellors as only important to Maori and Pakeha, and not to Asian clients in the vignette case examples. It suggests a surprisely "blindness" to Asian culture and identity in New Zealand on the part of the counsellor respondents in this study. The results may need further testing using potential Asian clients in the Asian communities in New Zealand for comparisons. If this is the case, the survey materials need to have both an English version and one in the mother-tongues of the selected Asian countries.

A number of possible explanations of the results for Asian clients may be due to the small sample size and and/or contextual factors in New Zealand. The contextual factors in New Zealand include: 1) The counsellor respondents have received greater **bi**cultural training; 2) Some Asian immigrants' English difficulty is treated as a main barrier and their cultural needs are sidelined; 3) The invisibility of Asian immigrants in bicultural centered context. These three aspects are explored as below.

1) The counsellor respondents have received greater bicultural training

a. The counsellor respondent demographic data indicated that the respondents have an advanced level of bicultural awareness and knowledge of working with Maori clients. Overall the percentages of the bicultural training were higher than the diverse cultural training.

b. The counsellor respondents might work with Maori clients or/and the clients' whanau, thus they have first hand experiences that culture-oriented counselling approaches have been accepted well by their Maori clients, and achieved better counselling outcomes than general counselling approaches could do.

c. The professional structure

- The majority of the counsellor respondents were members of professional bodies which have established and developed bicultural guidelines for research, training, practice, and continual professional and personal development. Generally, the guidelines talk about cross-cultural work between Pakeha professionals and Maori clients (Evans, Rucklidge, & O'Driscoll, 2007).
- Biculturalism has been a part of counselling training programs in tertiary educational settings. The professionals have had the opportunity to have contact with and learn Maori culture and bicultural communication at the very beginning of their career journey.
- Themes of the professional conferences, publications, and periodical communication materials in the field focus on working with Maori populations in parallel with the latest cutting-edge Western-oriented research and evidence-based practice for Pakeha populations.

2) Some Asian immigrants English needs may be centralised at the expanse of their cultural needs

In many social services, there is a long list of international language interpreters, but there is no such list for vast diverse ethnic cultural consultants. Often the clients would be described in terms of not speaking English or speaking poor English alongside their presenting clinical issues. When both English difficulty and cultural barriers are presented in the counselling room, the lack of English proficiency of the Asian clients might be treated as a major communication obstacle as if it could operate separately from its culture of origin while the client's cultural needs might be overlooked. When language barrier becomes centralised, the client's cultural needs can receive less attention. Culture plays a significant role in multicultural counselling

work, especially in terms of therapeutic relationship enhancement. In Asian culture, relationship building is at the heart of all kinds of human interaction.

Biculturalism is at the heart of New Zealand society, and the population is classified into Maori and non-Maori/Pakeha. The key features of Pakeha would include: mainstream, native-born, White, English-speaking, and of British and/or European descent. In the Asian example, Asian itself is not a homogenous group, with vast diversity in languages and cultures, often grouped into Central Asian, West Asian, and Southeast Asian. Specific ethnic cultural identity is not be recognized and acknowledged when these diverse subgroups and individuals are called Asian. Further, the whole Asian population may become invisible when they are classified as non-Maori/Pakeha.

Biculturalism is multidisciplinary but not multicultural in the contemporary New Zealand ethno-cultural context (Bromell, 2008). Multiculturalism has been perceived as a threat to biculturalism, an attempt to reject the distinctive role of the tangata whenua in New Zealand history, in the present, and the future, and a distraction Pakeha are using to manipulate the process of discussing unresolved issues between Maori and Crown, and Pakeha. This is a debate at political, historical, cultural, socieconomic, and public policy levels between indigenous peoples and the mainstream in Western countries, and between Maori and Pakeha in New Zealand (Bromell, 2008). When it comes to the population's health, multiculturalism promotes inclusiveness and tolerance of differences between individuals and communities, empowering minority ethnic populations to participate in the local community and the host society, and aiming at the enhancement of health and wellbeing of every one living in a particular community and country.

These multicultural ingredients are transferred to build a multicultural counselling body of knowledge for providing better services to all people (Sue & Sue, 2008). In this sense, multicultural counselling can serve the needs of the diverse ethnic cultural immigrant populations in New Zealand, who would not be self-identified as Maori or Pakeha.

The relationship between the indigenous Maori and Pakeha may be likened to an interracial marriage with issues over the colonial history, the process of post-colonialism, Maori sovereignty, land and resources, Te Reo and cultural aspirations, socioeconomic inequality, and the bi-cultural relationship. Based on this marriage, neighbourhood communities have been created and expanded, and other ethnic cultural populations have joined in as members of this expanded community, but not as a part of the marriage. The community focuses on developing respectful relationships, increasing mutual understanding, recognizing cultural diversity, and promoting inclusiveness, engagement, and participation. Marital issues and neighbourhood community relating do not belong to the same category. Viewed this way, multicultural work can have it own space without being put on hold until all bicultural issues are resolved satisfactorily.

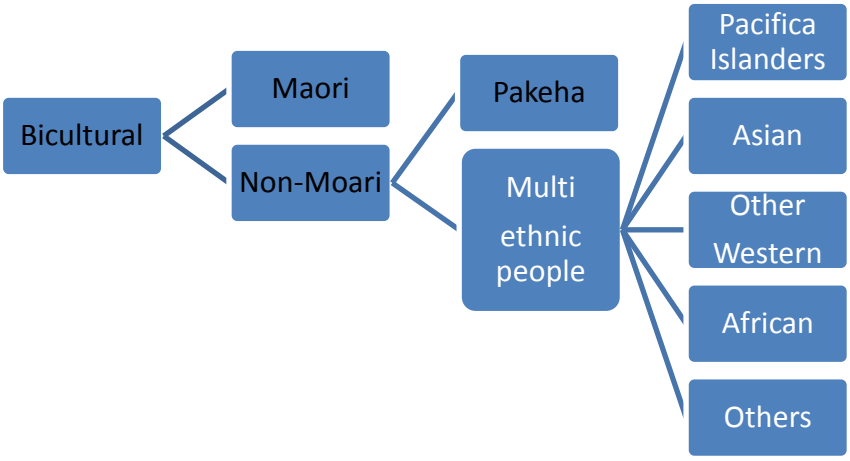
In the mental health context, the biculturally focused approach is to deliver culturally appropriate services to Maori clients, and a multicultural approach would address and deal with the needs of a diverse ethnic and cultural population. When people do not have a legitimated place they belong to in the New Zealand social-cultural map, they may become displaced and disconnected outsiders, which may disqualify them for building working relationships with the ‘visible’ people. The fact that minority ethnic cultural populations already have been under-users of mainstream psychological services, which means they could be further alienated and

isolated by the foreign social services in the host country (this can be one of many help-seeking barriers to them from the health services).

In the population health domain, biculturalism and multiculturalism are interrelated but each has its own focused issues and tasks. The multicultural approach is not in a position to compete with or replace the biculturally-centered approach (in black words in Figure 3 below); rather it can be added as a branch (in white words in Figure 3 below), to include minority ethnic immigrant people in the community as shown in Figure 3 below.

**Figure 3**

**Bicultural-centered approach includes multi ethnic people in New Zealand context**




The multicultural branch shown in the figure 3 above can offer a social and cultural place for a wide ethnic and cultural range of people who would not identify themselves as Maori or Pakeha. Multicultural issues are not uncommon in clinic settings in 21st century New Zealand. For example, a British immigrant female counsellor had as her clients, a Russian-Japanese immigrant couple who came to seek counselling because the Russian husband was having an affair with a Pakeha married woman whose husband was Maori. The Japanese wife was clinically depressed, the Russian husband was guilt-stricken, and the couple feared the reaction

of the Maori husband. If the counsellor worked from the Westen-oriented counselling treatment or the biculturally-focused approach, or a combination of the two approaches, the multicultural nature of this case might not be recognized or considered in the treatment plan and its implementation.

## Conclusion

From a theoretical level, culture-centered counselling can be useful and suitable for problem or pathological gambling in diverse ethnic cultural populations as it can translate and modify Western counselling approaches into more culturally accepted treatments. However, at the practice level, the process of the implementation of treatments entails many influential factors, such as how the potential services-users (clinicians, clients, and clients' families) might feel about the treatment, which would affect clinicians' treatment selection and recommendation, the level of clients' engagement with the process of treatment and their commitment to work on the presenting issues, the quality of the treatment delivery, and the treatment outcomes. In the process of implementation, alternative treatments evaluated by the potential consumers as important, appropriate, and fair are likely to encounter many fewer obstacles. Treatments that are supported empirically would not necessarily be well received and accepted by potential users. Acceptability of alternative treatments could operate independent from the efficacy of the treatments (Kazdin, 2003), but acceptability would affect the implementation of the treatments powerfully, simply because of the clients' refusal to engage with the treatments or premature drop-out of the treatment. Research into the acceptability of the alternative treatments is designed to test the potential service-users' subjective experience of selected treatments. This knowledge could provide useful information to help others make informed treatment

selections, treatment plans and implementation, additionally leading to further research on exploring ways to increase the acceptability levels of the treatments.

In this study, a survey on acceptability of alternative counselling treatments for problem or pathological gambling was conducted in New Zealand among practicing counsellors. Two measurements, the Treatment Evaluation Inventory (TEI) and the Cross Cultural Counselling Inventory-Revised (CCCI-R), were used. The TEI was used to measure the acceptability of one culture-centered counselling treatment, Solution-Focused Brief Counselling + Multicultural Counselling (SFBC+MC), and a general counselling treatment condition, Solution-Focused Brief Counselling (SFBC), for problem or pathological gambling across three client ethnicities, namely Pakeha, Maori, and Asian clients in vignette case examples, with two client genders (male, female) in the New Zealand context. As a control condition, the TEI was also used to measure the acceptability of Cognitive-Behavioural Therapy (CBT) and Motivational Interviewing (MI) for male and female Pakeha clients in vignette case examples. The CCCI-R was used to measure the cross-cultural counselling competency of counsellors depicted in vignette case examples.

The survey was distributed to counselling services providers in New Zealand. The TEI results showed significant differences in acceptability across clients' ethnicities and the treatments, and no differences across gender. The culture-centered approach, SFBC+MC, was most acceptable to counsellor respondents when depicted as delivered to Maori clients, and least acceptable when depicted as delivered to Asian clients in the vignette case examples. The CCCI-R results showed that counsellors using SFBC+MC were rated as the most culturally competent for Maori, Pakeha, and Asian clients in the vignette case examples compared to SFBC, and SFBC+MC was the most culturally competent approach for Pakeha compared to

CBT and MI. The results suggested that SFBC+MC, the culture-centered approach, would be likely well received and accepted by counsellor respondents when serving Maori clients with problem or pathological gambling in cross-cultural counselling settings. The results showed a puzzling picture that counsellors using SFBC+MC were viewed as more culturally competent than counsellors using SFBC for Asian clients in the vignette case examples, but the SFBC+MC condition was rated as the least acceptable for the Asian clients. This puzzled part did not support findings from the research literature in the multicultural counselling field, namely that the culture-centered approach would be more suitable than the general counselling approach for Asian clients. It appears that the Maori and Pakeha clients' cultural needs in the vignette case examples were visible and significant in intercultural counselling setting, but the Asian clients' cultural needs were less visible and less significant.

The findings provide evidence to help counselling service providers and training institutions consider problem or pathological gambling treatment selection, recommendations, and training programs, in a cross-cultural context. Additionally, the findings raise further research questions, such as what can be done to increase the degree of the acceptability of the alternative treatments for problem or pathological gambling, how to create space for developing multicultural counselling work and incorporate it in the bicultural-centered system in New Zealand, how to make current psychological services more flexible to include people from all cultural backgrounds who make their home in New Zealand, and finally, what needs to be looked at for increasing the sample size when research investigators want to conduct a survey from counselling service providers in New Zealand.

## Limitations

1. The small sample size limited our understanding of the acceptability of the treatment conditions and the clients' gender and ethnicity factors.
2. Based on the counsellor respondents' feedback:
   - 2.1. The vignette case description was the pencil-paper form which lacked information on body language or tone of voice compared to video or audio depictions.
   - 2.2. Some counsellor respondents preferred to do an online survey pack than the pencil-paper format
   - 2.3. The case description was mailed to the counsellor respondents and limited the respondents in having direct dialogue with the researchers for clarification about the case and the questionnaires
   - 2.4. Some counsellor respondents stated that the information in the case description was not sufficient to answer the questionnaires
   - 2.5. The case description did not present the way the counsellors in the vignette case examples worked on the alliance-building, and exclusively focused on treatment procedures. This might affect their rating scores
   - 2.6. The case description presented cross-cultural dialogue which might not be suitable to clients who preferred not to go there
3. The ethnic cultural groups did not include Pacific Islanders, a major ethnic group in New Zealand

## Future research suggestions

1) Future research into the acceptability of alternative treatment for problem or pathological gambling needs to consider the above limitations.

2) The counsellor respondent sample can expand to potential clients including affected Whanau and family members, the elderly and youth populations, and different socioeconomic communities.
3) It needs to repeat tests of the acceptability of alternative treatment for problem or pathological gambling, and also new survey questions around why culture-centered treatments would be less likely to be selected for Asian clients in New Zealand
4) More multicultural counselling research, training, and practice are needed to serve 21st Century New Zealand, a multicultural society. Multicultural psychological services and counselling guidelines need to be developed as a separate division to the current bicultural guidelines for all professionals and organizations providing psychological and counselling services.
5) The need for more research on immigrant population health and wellbeing in the process of resettlement in New Zealand is great. For example, research on Asian immigrant mental health has been under-conducted in Western countries, with little in New Zealand (Abbot, Wong, Williams, Au, & Wilson, 1999). The Asian population consists of 10% of the population in New Zealand, and has been a rapidly growing ethnic group in the last decade. Asian's health needs deserve attention from service providers.

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# APPENDICES

## Appendix A

### Information sheet

Kia Ora, Counsellors/Psychotherapists and Student Counsellors:

You are invited to participate in this survey on *Acceptability to Counsellors of Solution-focused brief counselling (SFBC), SFBC plus Multicultural counselling (SFBC+MC), Motivational Interviewing (MI), and Cognitive-behavioural therapy (CBT) for problem or pathological gambling in the New Zealand bicultural context.* I, Qing Tang, am undertaking this project for my Master Thesis in Psychology at the University of Canterbury.

**The purpose of this research**

As a counsellor you work in contemporary New Zealand society where biculturalism under the Treaty of Waitangi is a foundational principle. In recent years, the number of immigrants has increased rapidly which adds a multicultural dimension to New Zealand society. These cultural factors challenge counselling work profoundly. The aim of this survey is to identify which of four counselling models, incorporating either general or culture-centered principles, is more acceptable to counsellors working in New Zealand society. In this study, problem or pathological gambling is presented as the clinical case and the four models are SFBC, SFBC+MC, MI, and CBT.

If you agree to take part in this survey, you will be asked to read one vignette case describing a client with problem (or pathological) gambling, and a description of a treatment based on one counselling model. After you read the description of the case and its treatment, you will be asked to judge the counselling process by completing the Treatment Evaluation Inventory (TEI) and the Cross-Cultural Counselling Inventory-Revised (CCCI-R). The whole questionnaire might take you 10-20 minutes. Please use the enclosed prepaid addressed envelope to return the survey.

This survey is **anonymous**. The information you supply will be kept secure (in a locked filing cabinet in an office in the Department of Psychology and College of Education), and will be accessible only to the two supervisors and the research student. The findings are used in the thesis and may be submitted for publication. You can end your participation at any time by not returning the questionnaire. This study has been reviewed by the Human Ethics Committee, University of Canterbury and is supervised by Assoc. Prof. Neville Blampied, Department of Psychology, University of Canterbury, Private Bag 4800, Christchurch, telephone: 03-3642-199, email: neville.blampied@canterbury.ac.nz and Assoc. Prof. Judi Miller, College of Education, University of Canterbury, Private Bag 4800, Christchurch, telephone: 03-3642-546; email: judi.miller@canterbury.ac.nz.

If you have any concerns about participation in this survey, please contact Neville Blampied or Judi Miller or myself. If you want to have a copy of reference about articles related to this survey, please contact Qing Tang (MNZAC, MNZPsS), email: qta11@student.canterbury.ac.nz. Thank you very much for your participation!

# Appendix B

## Demongraphic data of the respondents

If you consent to participate in this survey, please begin the questionnaire below:

Please tick [ √ ]

Gender: F [ ] M [ ] Age: 20-30 [ ] 31-40 [ ] 41-50 [ ] 51-60 [ ] 61+ [ ]

Ethnicity: NZ European [ ] Maori [ ] Non-NZ European [ ] Pacific Island [ ] Asian [ ] Other [ ] please specify_____

Languages in which you are fluent: English [ ] Te Reo [ ]
other [ ] please specify_____

Please describe your counselling-orientation
Training (Your training institution/s and the main modality):
_____

Please indicate which of the following you have participated in

| Bicultural training: | Diverse cultural training: |
|---|---|
| [ ] The Treaty of Waitangi workshop | [ ] Cultural studies courses |
| [ ] Maori Marae-based training | [ ] Non-English language courses |
| [ ] Te Reo language course | [ ] Minority cultural supervision |
| [ ] Maori cultural supervision | [ ] Culture-centered workshop |
| [ ] Bi-cultural program | [ ] Multicultural research |
| [ ] Others_____ | [ ] Others _____ |

Length of time working in the counselling/psychotherapy field in New Zealand

_____month(s)/year(s)

If you were or are working in the field of treating problem gambling in New Zealand,

please indicate the total length of time you have worked in this area
_____month(s)/year(s)

Please read the vignette case below, and then complete the questionnaire that follows it.

# Appendix C

## Problem Gambling Treatment Evaluation Inventory

Please think about the scenario you have just read, and complete the ratings below with regard to that specific scenario. The items should be completed by placing a tick in the box on the line under the question that best indicates how your feel about the treatment. Please consider the scenario "as a whole" as you make your judgments.

1. Overall, how acceptable do you find the described treatment to be as a treatment for the client's problem gambling?

| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|
| not at all acceptable | | | moderately acceptable | | | very acceptable |

2. How willing would you be to use this treatment yourself if you had to assist a client with problem gambling?

| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|
| not at all willing | | | moderately willing | | | very willing |

3. How suitable is this treatment for clients who might have other problems than those described for this client?

| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|
| not at all suitable | | | moderately suitable | | | very suitable |

4. How well matched is the treatment to the needs of the client?

| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|
| very poorly | | | moderately well | | | very well matched |

5. How culturally appropriate do you find this treatment?

| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|
| very inappropriate | | | moderately appropriate | | | very appropriate |

6. Would it be acceptable to use this treatment with clients whose first language is not English and/or with other individuals such as very recent migrants?

| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|
| not at all acceptable | | | moderately acceptable | | | very acceptable |

7. How consistent is this treatment with common sense or everyday notions about what treatment for problem gambling should be?

| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|
| very different or inconsistent | | | moderately consistent | | | very consistent with common notions |

8. To what extent does this procedure respect the client's human rights?

| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|
| Not at all | | | moderately well | | | very well |

9. To what extent do you think there might be risks for the client in undergoing this kind of treatment?

| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|
| a great deal of risk | | | some risks | | | no risks |

10. How much do you personally like the procedures described in this treatment scenario?

| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|
| do not like them at all | | | moderately like them | | | like them very much |

11. How effective is this treatment likely to be?

| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|
| not at all effective | | | moderately effective | | | very effective |

12. How likely is this treatment to make permanent improvements for the client?

| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|
| unlikely | | | moderately | | | very likely |

13. To what extent are undesirable side effects likely to result from this treatment

| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|
| many undesirable side effects likely | | | some undesirable side effects likely | | | no undesirable side effects likely |

14. What do you think the client's reaction to the treatment is likely to be?

| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|
| very negative | | | Ambivalent/ neutral | | | very positive |

15. Overall, what is your general reaction to this treatment scenario?

| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|
| very negative | | | Ambivalent/ neutral | | | very positive |

Please make any additional comments here

## Cross Cultural Counselling Inventory—Revised

Assume that you are supervising to the counsellor depicted in the vignette case you have just read. The purpose of this inventory is to measure your perceptions about the Cross Cultural Counselling Competence of this counsellor. We are interested in your opinion so please make a judgment on the basis of what the statements in this inventory mean to you. In recording your response, please keep the following points in mind:

a. Please circle the appropriate rating under each statement.
b. Please circle only one response for each statement.
c. Be sure you check every scale even though you may feel that you have insufficient data on which to make a judgment—please do not omit any.

Rating Scale:
1= strongly disagree
2=disagree
3=neither agree nor disagree
4=agree
5=strongly agree

| | | | | | |
|---|---|---|---|---|---|
| 1. Counsellor is aware of his or her own cultural heritage. | 1 | 2 | 3 | 4 | 5 |
| 2. Counsellor values and respects cultural differences | 1 | 2 | 3 | 4 | 5 |
| 3. Counsellor is aware of how own values might affect this client. | 1 | 2 | 3 | 4 | 5 |
| 4. Counsellor is comfortable with differences between counsellor and client. | 1 | 2 | 3 | 4 | 5 |
| 5. Counsellor is willing to suggest referral when cultural differences are extensive | 1 | 2 | 3 | 4 | 5 |
| 6. Counsellor understands the current socio-political system and its impact on the client. | 1 | 2 | 3 | 4 | 5 |
| 7. Counsellor demonstrates knowledge about client's culture. | 1 | 2 | 3 | 4 | 5 |
| 8. Counsellor has a clear understanding of counselling and therapy process. | 1 | 2 | 3 | 4 | 5 |
| 9. Counsellor is aware of institutional barriers which might affect client's circumstance | 1 | 2 | 3 | 4 | 5 |
| 10. Counsellor elicits a variety of verbal and non-verbal responses from the client | 1 | 2 | 3 | 4 | 5 |

| | | | | | |
|---|---|---|---|---|---|
| 11. Counsellor accurately sends and receives a variety of verbal and non-verbal messages. | 1 | 2 | 3 | 4 | 5 |
| 12. Counsellor is able to suggest institutional intervention skills that favor the client. | 1 | 2 | 3 | 4 | 5 |
| 13. Counsellor sends messages that are appropriate to the communication of the client. | 1 | 2 | 3 | 4 | 5 |
| 14. Counsellor attempts to perceive the presenting problem within the context of the client's cultural experience, values, and/or lifestyle. | 1 | 2 | 3 | 4 | 5 |
| 15. Counsellor presents his or her own values to the client | 1 | 2 | 3 | 4 | 5 |
| 16. Counsellor is at ease talking with this client. | 1 | 2 | 3 | 4 | 5 |
| 17. Counsellor recognizes those limits determined by the cultural differences between client and counsellor. | 1 | 2 | 3 | 4 | 5 |
| 18. Counsellor appreciates the client's social status as an ethnic minority. | 1 | 2 | 3 | 4 | 5 |
| 19. Counsellor is aware of the professional and ethical responsibilities of a counsellor. | 1 | 2 | 3 | 4 | 5 |
| 20. Counsellor acknowledges and is comfortable with cultural differences. | 1 | 2 | 3 | 4 | 5 |

# Appedix D

## All data collection and statistic results

**Table 1.** TEI Frequency distribution of treatment/SFBC and SFBC+MC for Maori clients

| TEI/Maori/N | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| SFBC | 21 | 43 | 45 | 45 | 47 | 50 | 51 | 57 | 65 | 68 | 95 |
| SFBC+MC | 46 | 60 | 71 | 74 | 81 | 85 | 89 | 94 | 95 | 96 | 100 |

The scores were total TEI scores. The range of TEI scores is from 15 to 105. N=respondents. Maori clients were the clients described in case examples. SFBC and SFBC+MC were two treatment conditions.

**Table 1a.** TEI Mean distribution of the treatments for the Maori clients

| TEI/Maori | SFBC | SFBC+MC |
|---|---|---|
| Mean | 53.36 | 81 |
| SD | 18.57 | 16.87 |
| N | 11 | 11 |

**Figure 1.** TEI Frequency distribution of treatments/SFBC and SFBC+MC for Maori clients

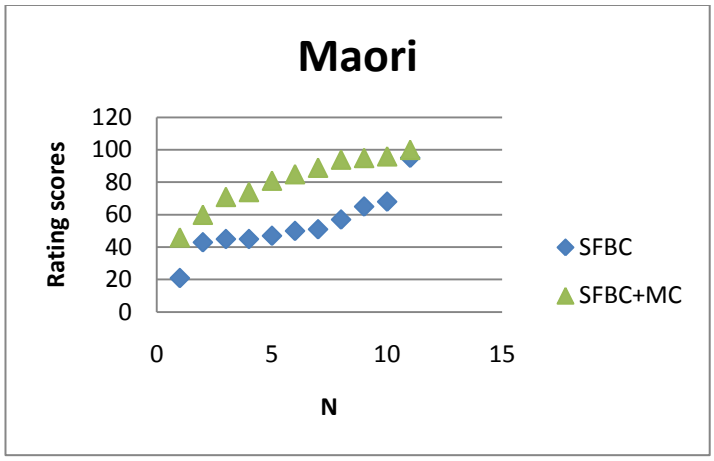

**Table 2.** TEI Frequency distribution of treatment/SFBC and SFBC+MC for Pakeha clients

| TEI/ Pakeha/N | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| SFBC | 52 | 64 | 71 | 74 | 82 | 83 | 86 | 87 | 90 | | | | | |
| SFBC+MC | 52 | 58 | 65 | 67 | 76 | 77 | 79 | 82 | 85 | 86 | 90 | 91 | 103 | 104 |
| CBT | 56 | 64 | 74 | 79 | 80 | 82 | 100 | | | | | | | |
| MI | 28 | 29 | 33 | 47 | 63 | 66 | 73 | 74 | 75 | 90 | 94 | | | |

The scores were total TEI scores. The range of TEI scores is from 15 to 105. N=respondents. SFBC, SFBC+MC, CBT, MI were treatment conditions. Pakeha clients were the clients described in case examples.

**Table 2a.** TEI Mean distribution of the treatments for the Pakeha clients

| TEI/Pakeha | SFBC | SFBC+MC | CBT | MI |
|---|---|---|---|---|
| Mean | 76.56 | 79.64 | 76.43 | 61.09 |
| SD | 12.49 | 15.38 | 14.04 | 23.58 |
| N | 9 | 14 | 7 | 11 |

**Figure 2.** TEI Frequency distribution of the treatments for the Pakeha clients

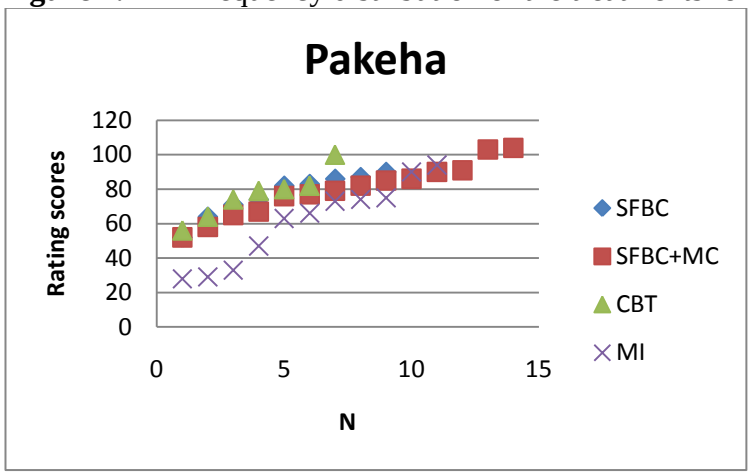


**Table 3.** TEI Frequency distribution of treatments/SFBC and SFBC+MC for Asian clients

| TEI/ Asian /N | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| SFBC | 50 | 51 | 51 | 55 | 81 | 86 | 90 | 97 | 103 | | | | | | |
| SFBC+MC | 45 | 47 | 49 | 60 | 62 | 63 | 66 | 69 | 69 | 74 | 77 | 79 | 81 | 88 | 89 |

The scores were total TEI scores. The range of TEI scores is from 15 to 105. N=respondents. SFBC, SFBC+MC, CBT, MI were treatment conditions. Asian clients were the clients described in case examples.

**Table 3a.** TEI/Mean distribution of the treatments for the Asian clients

| TEI/Asian | SFBC | SFBC+MC |
|---|---|---|
| Mean | 73.78 | 67.87 |
| SD | 21.83 | 13.91 |
| N | 9 | 15 |

**Figure 3.** TEI Frequency distribution of the treatments for the Asian clients

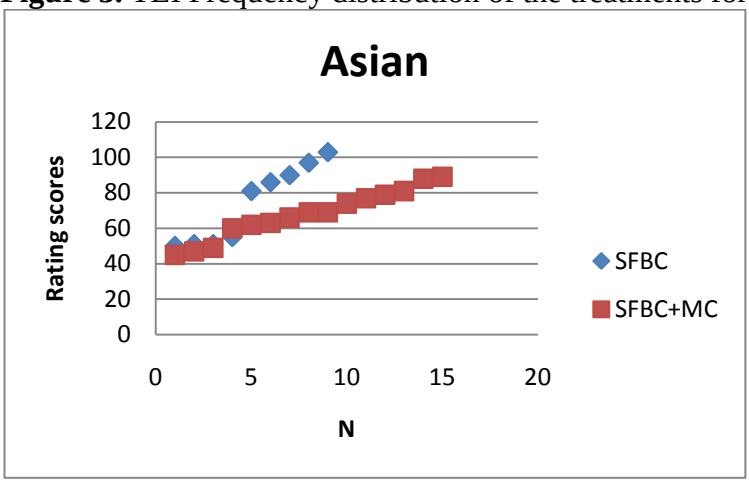


**Table 4.** CCCI-R Frequency distribution for treatments/SFBC and SFBC+MC for Maori clients

| CCCI-R/ Maori/N | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| SFBC | 29 | 39 | 43 | 46 | 50 | 56 | 56 | 63 | 64 | 64 | 70 | 72 | 89 |
| SFBC+MC | 70 | 73 | 77 | 79 | 80 | 84 | 85 | 86 | 89 | 89 | 93 | | |

The scores were total scores of CCCI-R. The range of CCCI-R is from 20 to 100. N=respondents. SFBC and SFBC+MC were treatment conditions. Maori clients were the clients described in case examples.

**Table 4a.** CCCI-R Mean distribution of the treatments for the Maori clients

| CCCI-R/ Maori | SFBC | SFBC+MC |
|---|---|---|
| Mean | 57 | 82.27 |
| SD | 15.89 | 7.14 |
| N | 13 | 11 |

**Figure 4.** CCCI-R Frequency distribution of the treatments for the Maori clients

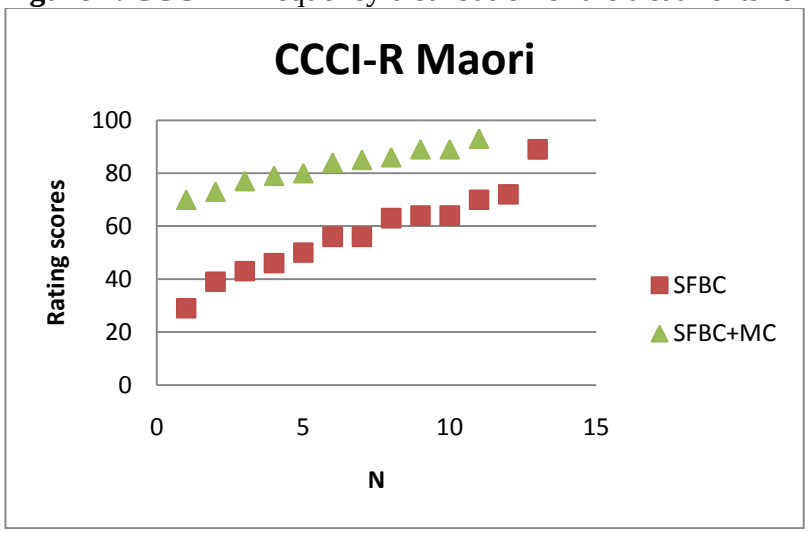


**Table 5.** CCCI-R Frequency distribution of treatments/SFBC, SFBC+MC, CBT, MI for Pakeha clients

| CCCI-R/ Pakeha/N | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| SFBC | 48 | 63 | 69 | 69 | 70 | 71 | 87 | 97 | | | | | |
| SFBC+MC | 40 | 66 | 69 | 69 | 73 | 73 | 74 | 74 | 75 | 76 | 80 | 92 | 97 |
| CBT | 59 | 61 | 67 | 69 | 71 | 74 | 76 | 94 | 97 | | | | |
| MI | 26 | 33 | 60 | 61 | 63 | 66 | 76 | 79 | | | | | |

The scores were total scores of CCCI-R. The range of CCCI-R is from 20 to 100. N=respondents. SFBC, SFBC+MC, SBT, MI were treatment conditions. Pakeha clients were the clients described in case examples.

**Table 5a.** CCCI-R Mean distribution of the treatments for the Pakeha clients

| CCCI-R/ Pakeha | SFBC | SFBC+MC | CBT | MI |
|---|---|---|---|---|
| Mean | 71.75 | 73.69 | 72.89 | 58 |
| SD | 14.78 | 13.43 | 13.67 | 18.96 |
| N | 8 | 13 | 9 | 8 |

**Figure 5.** CCCI-R Frequency distribution of the treatments for the Pakeha clients

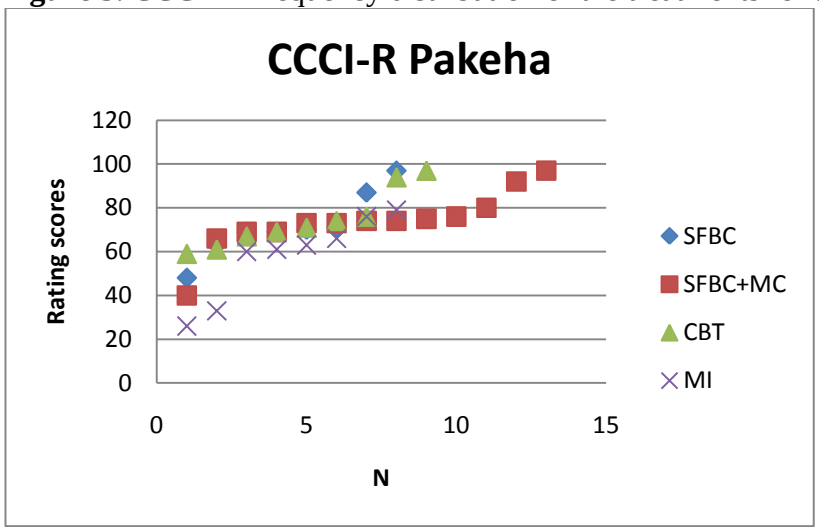


**Table 6.** CCCI-R Frequency distribution of treatments/SFBC and SFBC+MC for Asian clients

| CCCI-R/ Asian/N | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| SFBC | 33 | 36 | 44 | 55 | 57 | 64 | 65 | 65 | 70 | 77 | | | | | | |
| SFBC+MC | 53 | 54 | 59 | 62 | 65 | 67 | 67 | 70 | 73 | 74 | 76 | 77 | 81 | 85 | 86 | 86 |

The scores were total scores of CCCI-R. The range of CCCI-R is from 20 to 100. N=respondents. SFBC and SFBC+MC were treatment conditions. Asian clients were the clients described in case examples.

**Table 6a.** CCCI-R Mean distribution of the treatments for the Asian clients

| CCCI-R Asian | SFBC | SFBC+MC |
|---|---|---|
| Mean | 56.6 | 70.94 |
| SD | 14.66 | 10.73 |
| N | 10 | 16 |

**Figure 6.** CCCI-R Frequency distribution of the treatments for the Asian clients

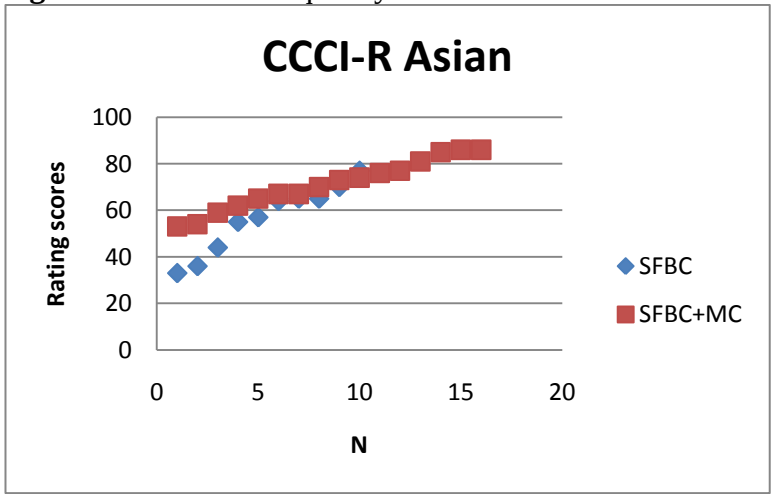

**Table 7.** TEI Frequency distribution of SFBC for Maori, Pakeha, and Asian clients

| SFBC/N | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Maori | 21 | 43 | 45 | 45 | 47 | 50 | 51 | 57 | 65 | 68 | 95 |
| Pakeha | 52 | 64 | 71 | 74 | 82 | 83 | 86 | 87 | 90 | | |
| Asian | 50 | 51 | 51 | 55 | 81 | 86 | 90 | 97 | 103 | | |

The scores were total scores of TEI. The range of TEI is from 15 to 105. N=respondents. SFBC was treatment condition. Maori, Pakeha, and Asian clients were the clients described in case examples.

**Table 7a.** TEI Mean distribution of SFBC for the Maori, the Pakeha, and the Asian clients

| TEI/SFBC | Maori | Pakeha | Asian |
|---|---|---|---|
| Mean | 53.36 | 76.56 | 73.78 |
| SD | 18.57 | 12.49 | 21.83 |
| N | 11 | 9 | 9 |

**Figure 7.** TEI Frequency distribution of SFBC for Maori, Pakeha, and Asian clients

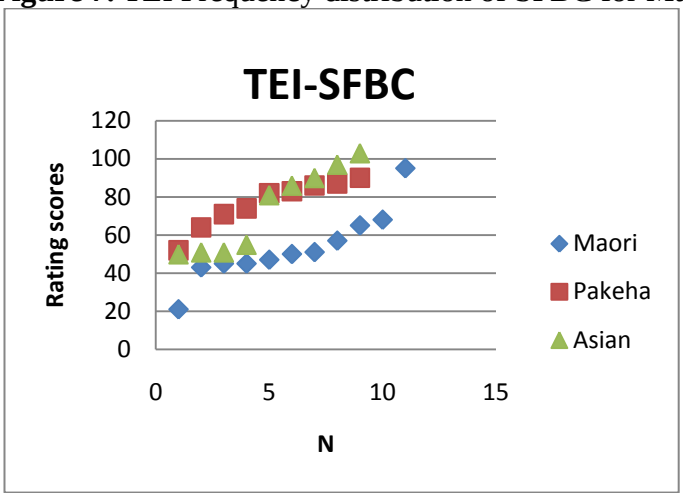


**Table 8.** TEI Frequency distribution of SFBC+MC for Maori, Pakeha, and Asian clients

| TEI/ SFMC+MC/N | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Maori | 46 | 60 | 71 | 74 | 81 | 85 | 85 | 89 | 94 | 95 | 96 | 100 | | | |
| Pakeha | 52 | 58 | 65 | 67 | 76 | 77 | 79 | 82 | 85 | 86 | 90 | 91 | 103 | 104 | |
| Asian | 45 | 47 | 49 | 60 | 62 | 63 | 66 | 69 | 69 | 74 | 77 | 79 | 81 | 88 | 89 |

The scores were total scores of TEI. The range of TEI is from 15 to 105.

N=respondents. SFBC+MC was treatment condition. Maori, Pakeha, and Asian clients were the clients described in case examples.

**Table 8a.** TEI Mean distribution of SFBC+MC for the Maori, the Pakeha, and the Asian clients

| TEI/SFBC+MC/N | Maori | Pakeha | Asian |
|---|---|---|---|
| Mean | 81 | 79.64 | 67.87 |
| SD | 16.87 | 15.38 | 13.91 |
| N | 11 | 14 | 15 |

**Figure 8.** TEI/SFBC+MC Frequency distribution of Maori, Pakeha, Asian

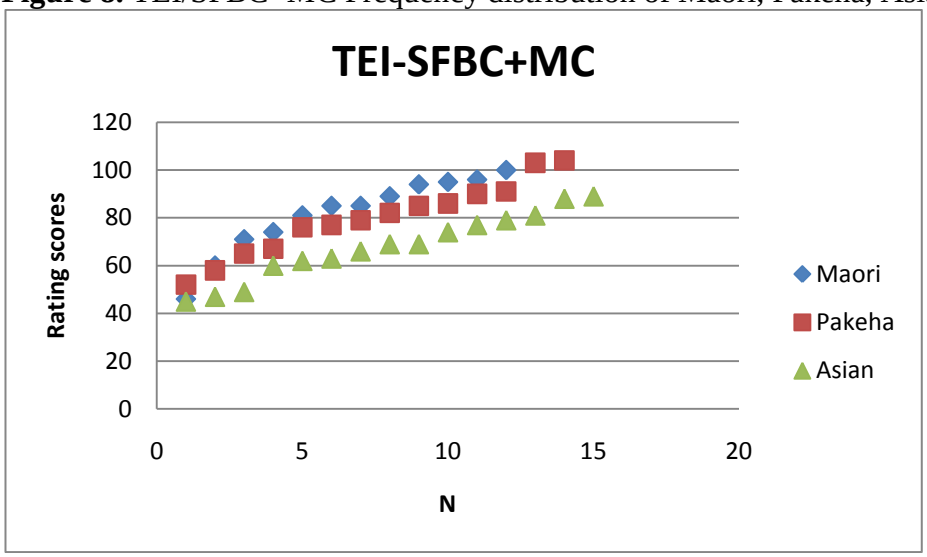


**Table 9.** CCCI-R Frequency distribution of SFBC for Maori, Pakeha, Asian clients

| CCCI-R/ SFBC/N | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Maori | 29 | 39 | 43 | 46 | 50 | 56 | 56 | 63 | 64 | 64 | 70 | 72 | 89 |
| Pakeha | 48 | 63 | 69 | 69 | 70 | 71 | 87 | 97 | | | | | |
| Asian | 33 | 36 | 44 | 55 | 57 | 64 | 65 | 65 | 70 | 77 | | | |

The scores were total scores of CCCI-R. The range of CCCI-R is from 20 to 100. N=respondents. SFBC was treatment condition. Maori, Pakeha, and Asian clients were the clients described in case examples.

**Table 9a.** CCCI-R Mean distribution of SFBC for the Maori, the Pakeha, and the Asian clients

| CCCI-R/ SFBC | Maori | Pakeha | Asian |
|---|---|---|---|
| Mean | 57 | 71.75 | 56.6 |
| SD | 15.89 | 14.78 | 14.66 |
| N | 13 | 8 | 10 |

**Figure 9.** CCCI-R Frequency distribution of SFBC for Maori, Pakeha, Asian clients

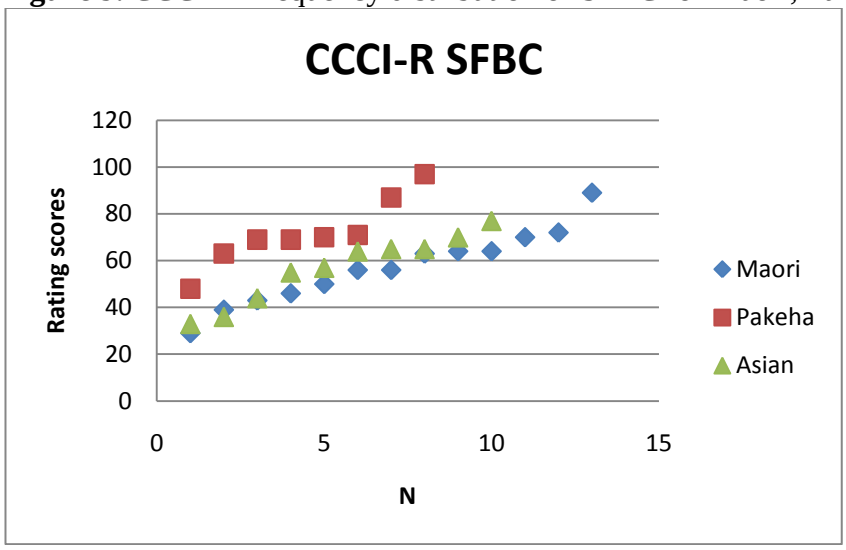


**Table 10.** CCCI-R Frequency distribution of SFBC+MC for Maori, Pakeha, Asian clients

| CCCI-R/ SFBC+MC/N | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Maori | 70 | 73 | 77 | 79 | 80 | 84 | 85 | 86 | 89 | 89 | 93 | | | | | |
| Pakeha | 40 | 66 | 69 | 69 | 73 | 73 | 74 | 74 | 75 | 76 | 80 | 92 | 97 | | | |
| Asian | 53 | 54 | 59 | 62 | 65 | 67 | 67 | 70 | 73 | 74 | 76 | 77 | 81 | 85 | 86 | 86 |

The scores were total scores of CCCI-R. The range of CCCI-R is from 20 to 100. N=respondents. SFBC+MC was treatment condition. Maori, Pakeha, and Asian clients were the clients described in case examples.

**Table 10a.** CCCI-R Mean distribution of SFBC+MC for the Maori, the Pakeha, and the Asian clients

| | Maori | Pakeha | Asian |
|---|---|---|---|
| Mean | 82.27 | 73.69 | 70.94 |
| SD | 7.14 | 13.43 | 10.73 |
| N | 11 | 13 | 16 |

**Figure10.** CCCI-R Frequency distribution of SFBC+MC for the Maori, the Pakeha, and the Asian clients

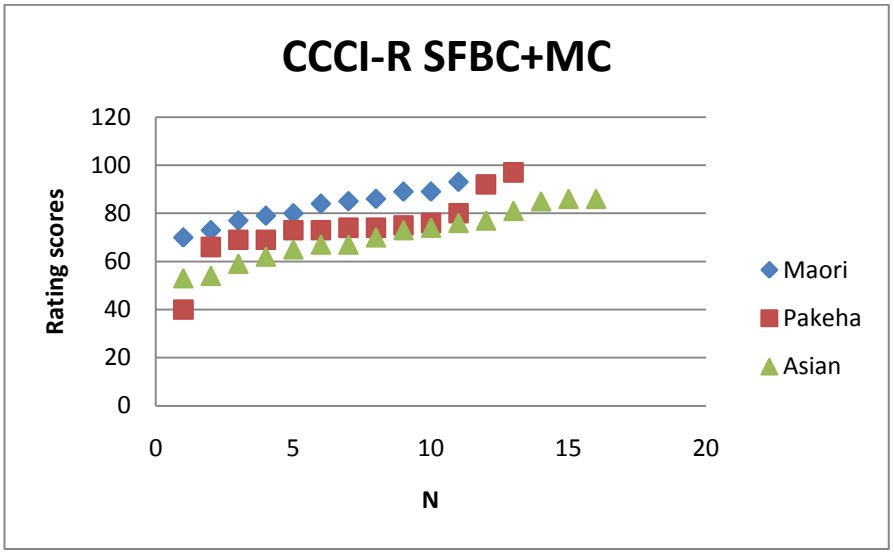


**Table 11.** TEI descriptive statistics

**Descriptive Statistics**

Dependent Variable: TEI total scores

| Treatment | Ethnicity Client | Mean | Std. Deviation | N |
|---|---|---|---|---|
| SFBC | Pakeha | 76.5556 | 12.49111 | 9 |
| | Maori | 53.3636 | 18.57026 | 11 |
| | Asian | 73.7778 | 21.83333 | 9 |
| | Total | 66.8966 | 20.52063 | 29 |
| SFBC+MC | Pakeha | 79.6429 | 15.38534 | 14 |
| | Maori | 81.0000 | 16.87009 | 11 |
| | Asian | 67.8667 | 13.91231 | 15 |
| | Total | 75.6000 | 16.07642 | 40 |
| CBT | Pakeha | 76.4286 | 14.04584 | 7 |
| | Total | 76.4286 | 14.04584 | 7 |
| MI | Pakeha | 61.0909 | 23.58158 | 11 |
| | Total | 61.0909 | 23.58158 | 11 |
| Total | Pakeha | 73.4390 | 18.32764 | 41 |
| | Maori | 67.1818 | 22.35565 | 22 |
| | Asian | 70.0833 | 17.09288 | 24 |
| | Total | 70.9310 | 19.05792 | 87 |

**Table 12**: Tests of Between-Subjects Effects/TEI Dependent Variable/Total scores

| Source | Type III Sum of Squares | df | Mean Square | F | Sig. |
|---|---|---|---|---|---|
| Corrected Model | 7347.692[a] | 7 | 1049.670 | 3.471 | .003 |
| Intercept | 317033.968 | 1 | 317033.968 | 1048.468 | .000 |
| Treatment | 3563.787 | 3 | 1187.929 | 3.929 | .011 |
| Eth_Client | 1357.091 | 2 | 678.545 | 2.244 | .113 |
| Treatment * Eth_Client | 3341.003 | 2 | 1670.501 | 5.525 | .006 |
| Error | 23887.894 | 79 | 302.378 | | |
| Total | 468951.000 | 87 | | | |
| Corrected Total | 31235.586 | 86 | | | |

a. R Squared = .235 (Adjusted R Squared = .167)

**Table 13**: Treatment/TEI Dependent Variable/ Total scores

| Treatment | Mean | Std. Error | 95% Confidence Interval | |
|---|---|---|---|---|
| | | | Lower Bound | Upper Bound |
| SFBC | 67.899 | 3.244 | 61.443 | 74.355 |
| SFBC+MC | 76.170 | 2.774 | 70.649 | 81.691 |
| CBT | 76.429[a] | 6.572 | 63.346 | 89.511 |
| MI | 61.091[a] | 5.243 | 50.655 | 71.527 |

a. Based on modified population marginal mean.

**Table 14**: Ethnicity/Client /TEI Dependent Variable/Total scores

| Ethnitic Client | Mean | Std. Error | 95% Confidence Interval | |
|---|---|---|---|---|
| | | | Lower Bound | Upper Bound |
| Pakeha | 73.429 | 2.805 | 67.846 | 79.013 |
| Maori | 67.182[a] | 3.707 | 59.803 | 74.561 |
| Asian | 70.822[a] | 3.666 | 63.525 | 78.119 |

a. Based on modified population marginal mean.

**Table 15.** Descriptive statistics for CCCI-R

**Descriptive Statistics**

Dependent Variable: CCCI-R/Total scores

| Treatment | Ethnicity Client | Mean | Std. Deviation | N |
|---|---|---|---|---|
| SFBC | Pakeha | 71.7500 | 14.78175 | 8 |
| | Maori | 57.0000 | 15.88500 | 13 |
| | Asian | 56.6000 | 14.66060 | 10 |
| | Total | 60.6774 | 16.13978 | 31 |
| SFBC_MC | Pakeha | 73.6923 | 13.43121 | 13 |
| | Maori | 82.2727 | 7.14270 | 11 |
| | Asian | 70.9375 | 10.72983 | 16 |
| | Total | 74.9500 | 11.62436 | 40 |
| CBT | Pakeha | 72.8889 | 13.66972 | 9 |
| | Total | 72.8889 | 13.66972 | 9 |
| mi | Pakeha | 58.0000 | 18.95860 | 8 |
| | Total | 58.0000 | 18.95860 | 8 |
| Total | Pakeha | 69.7895 | 15.71049 | 38 |
| | Maori | 68.5833 | 17.86889 | 24 |
| | Asian | 65.4231 | 14.03759 | 26 |
| | Total | 68.1705 | 15.79409 | 88 |

**Table 16.**

**Tests of Between-Subjects Effects**

Dependent Variable: CCCI-R/Total scores

| Source | Type III Sum of Squares | df | Mean Square | F | Sig. |
|---|---|---|---|---|---|
| Corrected Model | 6797.766[a] | 7 | 971.109 | 5.212 | .000 |
| Intercept | 302439.363 | 1 | 302439.363 | 1623.326 | .000 |
| Treatment | 4884.737 | 3 | 1628.246 | 8.740 | .000 |
| Eth_Client | 934.268 | 2 | 467.134 | 2.507 | .088 |
| Treatment * Eth_Client | 1472.548 | 2 | 736.274 | 3.952 | .023 |
| Error | 14904.677 | 80 | 186.308 | | |
| Total | 430657.000 | 88 | | | |
| Corrected Total | 21702.443 | 87 | | | |

a. R Squared = .313 (Adjusted R Squared = .253)

**Table 17. Treatments**

**Treatment**

Dependent Variable: CCCI-R/Total scores

| Treatment | Mean | Std. Error | 95% Confidence Interval | |
|---|---|---|---|---|
| | | | Lower Bound | Upper Bound |
| SFBC | 61.783 | 2.500 | 56.808 | 66.759 |
| SFBC+MC | 75.634 | 2.184 | 71.289 | 79.980 |
| CBT | 72.889[a] | 4.550 | 63.834 | 81.943 |
| MI | 58.000[a] | 4.826 | 48.396 | 67.604 |

a. Based on modified population marginal mean.

**Table 18. Ethnicity clients**

**Ethnicity of Client**

Dependent Variable: CCCI-R/Total scores

| Ethnicity Client | Mean | Std. Error | 95% Confidence Interval | |
|---|---|---|---|---|
| | | | Lower Bound | Upper Bound |
| Pakeha | 69.083 | 2.258 | 64.588 | 73.577 |
| Maori | 69.636[a] | 2.796 | 64.072 | 75.200 |
| Asian | 63.769[a] | 2.751 | 58.294 | 69.244 |

a. Based on modified population marginal mean.

# Appendix E

## Four treatment conditions

### Solution-focused brief counselling (SFBC)

The ultimate goal of SFBC is to help the client recognize those workable strategies they already have, and strengthen their commitment to bring about the changes he/she wants. The principles of SFBC are brief, strength-based, goal-focused, client-centred, emphasizing behavioural and attitude change, and inducing creativity for solution-building. Basic SFBC procedures include: 1. Using a *pre-session change* question to discover changes that have occurred between the time the clients made the appointment and the time they attend it. This is for exploring the client's own solutions; 2. A *scaling* question is often used for goal-setting and progress-measuring; 3. A *miracle morning* question asks clients to draw out a vision of the future when a problem is absent; 4. An *exception*-finding/amplifying question is used to identify what works already and/or may work; 5. At the end of each session, the counsellor gives feedback on the client's possible solution strategies and assigns homework.

### Solution-focused brief counselling (SFBC)+Multicultural counselling (MC)

The ultimate goal of SFBC is to help the client recognize those workable strategies they already have, and strengthen their commitment to bring about the changes he/she wants. The principles of SFBC are brief, strength-based, goal-focused, client-centred, emphasizing behavioural and attitude change, and inducing creativity for solution-building. Basic SFBC procedures include: 1. Using a *pre-session change* question to discover changes that have occurred between the time the clients made the appointment and the time they attend it. This is for exploring the client's own solutions; 2. A *scaling* question is often used for goal-setting and progress-measuring; 3. A *miracle morning* question asks clients to draw out a vision of the future when a problem is absent; 4. An *exception*-finding/amplifying question is used to identify what works already and/or may work; 5. At the end of each session, the counsellor gives feedback on the client's possible solution strategies and assigns homework.

The main components of MC interviewing include: developing self-awareness in the counsellor's own culture and bias; checking out the client's preference for the counsellor's culture and language; clarifying the client's expectations of the counselling process; identifying the client's levels of acculturation; recognizing those expectations the client's family and ethnic community have on her or him; always respecting and valuing the client's worldview of the presenting problem and solutions; building a trusting relationship and appreciating the extra challenge present in cross-cultural relationship; the need to have an awareness of culture-based behaviours; being flexible and creative in those standard techniques; using culture-centred counselling skills and implementing culturally appropriate and relevant intervention.

### Cognitive behavioural therapy(CBT)

CBT is an evidence-based approach with a focus on cognitive and behavioural change. The content of CBT includes correcting cognitive distortions, restructuring cognitive processes, dealing with irrational beliefs and attitudes, reducing dysfunctional thinking and decreasing self-defeating behaviours, as well as providing stress management training and problem-solving skills. The process of CBT is often directive, structured, educative, brief, goal-oriented, action-focused, assisting clients to examine thought patterns, emotional responses, and behavioural reactions; and using reality-checking to dispute irrational core beliefs and co-designing homework or following self-help workbooks.

## Motivational interviewing (MI)

MI is a process to elicit clients' motivation for change and enhance their commitment to continuing the progress, focusing on problem-solving, emphasizing goal-setting and behavioural change, and providing a structured and directive conversation. MI is not for fixing multiple problems of living, a chaotic lifestyle, or a high need for emotional expression. The main procedures include: 1) Using a Transtheoretical Model to assess a client's stage of change, including *precontemplation, contemplation, preparation, action,* and *maintenance.* Each stage has its own tasks and interventions. 2) Identifying therapy goals that need the client's agreement. 3) Choosing intervention that should match the client's stage of change and facilitate him/her to move to the next level. 4) Inviting the client to take responsibility and promoting self-efficacy. 5) Developing a relapse prevention plan.

# Appendix F

## Sixteen vignette case examples

**Scenario 1**

Solution Focused Brief Counselling (SFBC) treating problem or pathological gambling

**Vignette case description**

Michael is a 27-year-old Pakeha male who was introduced to betting on horse races by his parents in his early adolescence. Michael's partner has taken control of the family finances as he often gambles all their money. Recently, Michael stole goods from his work to fund his gambling, but Michael's boss decided to give him a second chance if he would see a counsellor. Michael meets the criteria for pathological gambling based on his DSM-IV-TR and SOGS scores.

The ultimate goal of SFBC is to help the client recognize those workable strategies they already have, and strengthen their commitment to bring about the changes he/she wants. The principles of SFBC are brief, strength-based, goal-focused, client-centred, emphasizing behavioural and attitude change, and inducing creativity for solution-building. Basic SFBC procedures include: 1. Using a *pre-session change* question to discover changes that have occurred between the time the clients made the appointment and the time they attend it. This is for exploring the client's own solutions; 2. A s*caling* question is often used for goal-setting and progress-measuring; 3. A *miracle morning* question asks clients to draw out a vision of the future when a problem is absent; 4. An *exception*-finding/amplifying question is used to identify what works already and/or may work; 5. At the end of each session, the counsellor gives feedback on the client's possible solution strategies and assigns homework.

**Description of the first session**

The counsellor, a non-Pakeha female, asks Michael about *pre-session change* and learns that he has not gambled for one week (his exception) and he uses three strategies to help himself: 1) self-talking – e.g, 'do not go there, you can do it'; 2) reminding himself about the devastating effects of his gambling on himself, and his work; 3) avoiding gambling venues. On the scale of his experience of problematic gambling, where 1/10 is completely out of his control, 10/10 is fully under his control, Michael gives himself a 2/10 for now and wants to move up to a 7/10 where he would be able to walk away from a gambling venue after spending $10 and go there once a week. Michael describes his *miracle morning* as he could stop thinking those gambling thoughts, feel relaxed, be his own person, and live a normal life. Michael reveals that he has experienced a little bit of this miracle when he has told his partner about his stealing.

By helping him externalize his gambling problem, the counsellor affirms the effect of the problem on his life, but also points out that the problem does not define him as a person and cannot hold him back from living life to the fullest. At the end, she compliments Michael's exception, encourages him to keep doing what works for him so far, and expresses her faith in Michael's ability to reach his goals eventually. Homework for him is to ponder what it takes him to move from 2/10 to 3/10 and what he would be doing if he moved to 3/10.

**Scenario 2**

## Solution Focused Brief Counselling (SFBC) + Multicultural Counselling (MC) treating problem or pathological gambling

**Vignette case description**

Michael is a 27-year-old Pakeha male who was introduced to betting on horse races by his parents in his early adolescence. Michael's partner has taken control of the family finances as he often gambles all their money. Recently, Michael stole goods from his work to fund his gambling, but Michael's boss decided to give him a second chance if he would see a counsellor. Michael meets the criteria for pathological gambling based on his DSM-IV-TR and SOGS scores.

The ultimate goal of SFBC is to help the client recognize those workable strategies they already have, and strengthen their commitment to bring about the changes he/she wants. The principles of SFBC are brief, strength-based, goal-focused, client-centred, emphasizing behavioural and attitude change, and inducing creativity for solution-building. Basic SFBC procedures include: 1. Using a *pre-session change* question to discover changes that have occurred between the time the clients made the appointment and the time they attend it. This is for exploring the client's own solutions; 2. A *scaling* question is often used for goal-setting and progress-measuring; 3. A *miracle morning* question asks clients to draw out a vision of the future when a problem is absent; 4. An *exception*-finding/amplifying question is used to identify what works already and/or may work; 5. At the end of each session, the counsellor gives feedback on the client's possible solution strategies and assigns homework.

The main components of MC interviewing include: developing self-awareness in the counsellor's own culture and bias; checking out the client's preference for the counsellor's culture and language; clarifying the client's expectations of the counselling process; identifying the client's levels of acculturation; recognizing those expectations the client's family and ethnic community have of her or him; always respecting and valuing the client's worldview on the presenting problem and solutions; building a trusting relationship and appreciating the extra challenge present in cross-cultural relationships; the need to have awareness of culture-based behaviours; being flexible and creative in those standard techniques; using culture-centred counselling skills and implementing culturally appropriate and relevant interventions.

**Description of the first session**

The counsellor, a non-Pakeha female, first expresses her thoughts that their cultural (and gender) differences might affect the counselling relationship and checks with Michael about his counsellor preference. The counsellor asks Michael to tell her any relevant cultural aspects she needs to know to work effectively with him, and checks with him whether he is happy to do this.

The counsellor asks about *pre-session change* and learns that he has not gambled for one week (his exception) and he uses three strategies to help himself: 1) self-talking – e.g., 'do not go there, you can do it'; 2) reminding himself about the devastating effects of his gambling on himself and his work; 3) avoiding gambling venues. On the scale of his experience of problem gambling, where 1/10 is completely out of his

control, 10/10 is fully under his control, Michael gives himself a 2/10 for now and wants to move up to 7/10 where he would be able to walk away from a gambling venue after spending $10 and go there once a week.

The counsellor asks Michael what types of gambling are thought to be acceptable in his culture, how Pakeha people manage their gambling behaviours, and how will it feel for him to manage his gambling. Michael recognizes that many resources regarding gambling management are available and accessible in the local community.

By helping him externalize his gambling problem, the counsellor affirms the effect of the problem on his life, but also points out that the problem does not define him as a person and cannot hold him back from living life to the fullest. Then Michael describes his *miracle morning* as he could stop thinking those gambling thoughts, feel relaxed, be his own person, and live a normal life. He reveals that he has experienced a little bit of this miracle when he has told his partner about his stealing. The counsellor asks Michael what it means to be his own person, how his partner can notice it, what a normal day will be like, and then what he will be doing.

At the end, the counsellor checks with Michael about how he views working with a culturally different counsellor, the counselling process, and what he thinks she needs to learn about his culture The counsellor compliments Michael's exception, encourages him to keep doing what works for him so far, expresses her faith in Michael's ability to reach his goals eventually, and appreciates him for sharing his culture knowledge. Homework for him is to ponder what it takes him to move from 2/10 to 3/10 and what he would be doing if he moved to 3/10.

**Scenario 3**

## Solution Focused Brief Counselling (SFBC) treating problem or pathological gambling

**Vignette case description**

Kate is 20-year-old Pakeha female who started gambling on the pokies two years ago. She won two jackpots on one single day, which was the first time in her life she had played the pokies. In the following two years, she has gambled every day and is deeply in debt. Eventually, Kate's parents had bailed her out with the condition that she must go to see a counsellor. Kate meets the criteria for pathological gambling based on her DSM-IV-TR and SOGS scores.

The ultimate goal of SFBC is to help the client recognize those workable strategies they already have, and strengthen their commitment to bring about the changes he/she wants. The principles of SFBC are brief, strength-based, goal-focused, client-centred, emphasizing behavioural and attitude change, and inducing creativity for solution-building. Basic SFBC procedures include: 1. Using a *pre-session change* question to discover changes that have occurred between the time the clients made the appointment and the time they attend it. This is for exploring the client's own solutions; 2. A *scaling* question is often used for goal-setting and progress-measuring; 3. A *miracle morning* question asks clients to draw out a vision of the future when a problem is absent; 4. An *exception*-finding/amplifying question is used to identify what works already and/or may work; 5. At the end of each session, the counsellor gives feedback on the client's possible solution strategies and assigns homework.

**Description of the first session**

The counsellor, a non-Pakeha male, asks Kate about *pre-session change* and learns that she has not gambled for one week (her exception) and she uses three strategies to help herself: 1) self-talking – e.g, 'do not go there, you can do it'; 2) reminding herself about the devastating effects of her gambling on herself and her family; 3) avoiding gambling venues. On the scale of her experience of problem gambling, where 1/10 is completely out of her control, 10/10 is fully under her control, Kate gives herself a 2/10 for now and wants to move up to a 7/10 where she would be able to walk away from a gambling venue after spending $10 and go there once a week. Kate described her *miracle morning* as she could stop thinking those gambling thoughts, feel relaxed, be her own person, and live a normal life. Kate reveals that she has experienced a little bit of this miracle when she has told her parents about her problem.

By helping her externalize her gambling problem, the counsellor affirms the effect of the problem on her life, but also points out that the problem does not define her as a person and cannot hold her back from living life to the fullest. At the end, he compliments Kate's exception, encourages her to keep doing what works for her so far, and expresses his faith in Kate's ability to reach her goals eventually. Homework for her is to ponder what it takes her to move from 2/10 to 3/10 and what she would be doing if she moved to 3/10.

**Scenario 4**

## Solution Focused Brief Counselling (SFBC) + Multicultural Counselling (MC) treating problem or pathological gambling

**Vignette case description**

Kate is 20-year-old Pakeha female who started gambling on the pokies two years ago. She won two jackpots on one single day, which was the first time in her life she had played the pokies. In the following two years, she has gambled every day and is deeply in debt. Eventually, Kate's parents had bailed her out with the condition that she must go to see a counsellor. Kate meets the criteria for pathological gambling based on her DSM-IV-TR and SOGS scores.

The ultimate goal of SFBC is to help the client recognize those workable strategies they already have, and strengthen their commitment to bring about the changes he/she wants. The principles of SFBC are brief, strength-based, goal-focused, client-centred, emphasizing behavioural and attitude change, and inducing creativity for solution-building. Basic SFBC procedures include: 1. Using a *pre-session change* question to discover changes that have occurred between the time the clients made the appointment and the time they attend it. This is for exploring the client's own solutions; 2. A *scaling* question is often used for goal-setting and progress-measuring; 3. A *miracle morning* question asks clients to draw out a vision of the future when a problem is absent; 4. An *exception*-finding/amplifying question is used to identify what works already and/or may work; 5. At the end of each session, the counsellor gives feedback on the client's possible solution strategies and assigns homework.

The main components of MC interviewing include: developing self-awareness in the counsellor's own culture and bias; checking out the client's preference for the counsellor's culture and language; clarifying the client's expectations of the counselling process; identifying the client's levels of acculturation; recognizing those expectation the client's family and ethnic community have of her or him; always respecting and valuing the client's worldview on the presenting problem and solutions; building a trusting relationship and appreciating the extra challenge present in cross-cultural relationships; the need to have an awareness of culture-based behaviours; being flexible and creative with those standard techniques; using culture-centred counselling skills and implementing culturally appropriate and relevant interventions.

**Description of the first session**

The counsellor, a non-Pakeha male, first expresses his thoughts that their cultural (and gender) differences might affect the counselling relationship and checks with Kate about her counsellor preference. The counsellor asks Kate to tell him any relevant cultural aspects he needs to know to work effectively with her, and checks with her whether she is happy do this.

The counsellor asks about *pre-session change* and learns that she has not gambled for one week (her exception) and she uses three strategies to help herself: 1) self-talking – e.g., 'do not go there, you can do it'; 2) reminding herself about the devastating effects of her gambling on herself and her family; 3) avoiding gambling venues. On the scale of her experience of problem gambling, where 1/10 is completely out of her control, 10/10 is fully under her control, Kate gives herself a 2/10 for now and wants

to move up to 7/10 where she would be able to walk away from a gambling venue after spending $10 and go there once a week.

The counsellor asks Kate what types of gambling are thought to be acceptable in her culture, how Pakeha people manage their gambling behaviours, and how will it feel for her to manage her gambling. Kate recognizes that many resources regarding gambling management are available and accessible in the local community.

By helping her externalize her gambling problem, the counsellor affirms the effect of the problem on her life, but also points out that the problem does not define her as a person and cannot hold her back from living life to the fullest. Kate describes her *miracle morning* as she could stop thinking those gambling thoughts, feel relaxed, be her own person, and live a normal life. She reveals that she has experienced a little bit of this miracle when she has told her parents about her gambling. The counsellor asks Kate what it means to be her own person, how her parents can notice it, what a normal day will be like, and then what she will be doing.

At the end, the counsellor checks with Kate how she views working with a culturally different counsellor, the counselling process, and what she thinks he needs to learn about her culture. The counsellor compliments Kate's exception, encourages her to keep doing what works for her so far, expresses his faith in Kate's ability to reach her goals eventually, and appreciates her for sharing her culture knowledge. Homework for her is to ponder what it takes her to move from 2/10 to 3/10 and what she would be doing if she moved to 3/10.

**Scenario 5**

## Solution Focused Brief Counselling (SFBC) treating problem or pathological gambling

**Vignette case description**

Piripi is 35-year-old Maori male, living with his wife, their two preschool children, his mother, and his nephew. Piripi's wife dislikes him spending money on gambling so she has taken control of the family finances. In the last month, his wife took the children to visit her family overseas and she left Piripi a bank card with $10,000 to lend to her cousin for buying him a car and for bills and daily costs. Piripi has gambled and lost $9,000 of this money. He has come counselling and wants to sort his problem out before his wife returns to the country. Piripi meets the criteria for pathological gambling based on his DSM-IV-TR and SOGS scores.

The ultimate goal of SFBC is to help the client recognize those workable strategies they already have, and strengthen their commitment to bring about the changes he/she wants. The principles of SFBC are brief, strength-based, goal-focused, client-centred, emphasizing behavioural and attitude change, and inducing creativity for solution-building. Basic SFBC procedures include: 1. Using a *pre-session change* question to discover changes that have occurred between the time the clients made the appointment and the time they attend it. This is for exploring the client's own solutions; 2. A *scaling* question is often used for goal-setting and progress-measuring; 3. A *miracle morning* question asks clients to draw out a vision of the future when a problem is absent; 4. An *exception*-finding/amplifying question is used to identify what works already and/or may work; 5. At the end of each session, the counsellor gives feedback on the client's possible solution strategies and assigns homework.

**Description of the first session**

The counsellor, a Pakeha female, asks Piripi about *pre-session change* and learns that he has not gambled for one week (his exception) and he uses three strategies to help himself: 1) self-talking – e.g., 'do not go there, you can do it'; 2) reminding himself about the devastating effects of his gambling on himself and his whānau; 3) avoiding gambling venues. On the scale of his experience of problem gambling, where 1/10 is completely out of his control, 10/10 is fully under his control, Piripi gives himself a 2/10 for now and wants to move up to a 7/10 where he would be able to walk away from a gambling venue after spending $10 and go there once a week. Piripi describes his *miracle morning* as he could stop thinking those gambling thoughts, feel relaxed, and live a normal life. Piripi reveals that he has experienced a little bit of this miracle when he has told his mother about his gambling.

By helping him externalize his gambling problem, the counsellor affirms the effect of the problem on his life, but also points out that the problem does not define him as a person and cannot hold him back from living life to the fullest. At the end, she compliments Piripi's exception, encourages him to keep doing what works for him so far, and expresses her faith in Piripi's ability to reach his goals eventually.

Homework for him is to ponder what it takes him to move from 2/10 to 3/10 and what he would be doing if he moved to 3/10.

**Scenario 6**

## Solution Focused Brief Counselling (SFBC) + Multicultural Counselling (MC) treating problem or pathological gambling

**Vignette case description**

Piripi is 35-year-old Maori male, living with his wife, their two preschool children, his mother, and his nephew. Piripi's wife dislikes him spending money on gambling so she has taken control of the family finances. In the last month, his wife took the children to visit her family overseas and she left Piripi a bank card with $10,000 to lend to her cousin for buying him a car and for bills and daily costs. Piripi has gambled and lost $9,000 of the money. He has come counselling and wants to sort his problem out before his wife returns to the country. Piripi meets the criteria for pathological gambling based on his DSM-IV-TR and SOGS scores.

The ultimate goal of SFBC is to help the client recognize those workable strategies they already have, and strengthen their commitment to bring about the changes he/she wants. The principles of SFBC are brief, strength-based, goal-focused, client-centred, emphasizing behavioural and attitude change, and inducing creativity for solution-building. Basic SFBC procedures include: 1. Using a *pre-session change* question to discover changes that have occurred between the time the clients made the appointment and the time they attend it. This is for exploring the client's own solutions; 2. A *scaling* question is often used for goal-setting and progress-measuring; 3. An *miracle morning* question asks clients to draw out a vision of the future when a problem is absent; 4. An *exception*-finding/amplifying question is used to identify what works already and/or may work; 5. At the end of each session, the counsellor gives feedback on the client's possible solution strategies and assigns homework.

The main components of MC interviewing include: developing self-awareness in the counsellor's own culture and bias; checking out the client's preference for the counsellor's culture and language; clarifying the client's expectations of the counselling process; identifying the client's levels of acculturation; recognizing those expectations the client's family and ethnic community have of her or him; always respecting and valuing the client's worldview on the presenting problem and solutions; building a trusting relationship and appreciating the extra challenge present in cross-cultural relationship; the need to have awareness of culture-based behaviours; be flexible and creative in those standard techniques; using culture-cantered counselling skills and implementing culturally appropriate and relevant interventions.

**Description of the first session**

The counsellor, a Pakeha female, puts Maori flax flowers and a flax weaving basket in the room and places a New Zealand map showing Maori iwi on the wall. She explains to Piripi that she does not speak Te Reo and she appreciates the uniqueness of Maori culture. She provides Piripi a list of Maori counselling agencies and Marae-based helpers. She expresses her thoughts that their cultural (and gender) differences might affect the counselling relationship and checks with Piripi about his counsellor preference. She asks Piripi to tell her any relevant cultural aspects she needs to know for working effectively with him, and invites him to bring a support person to sessions if he wants. She also checks with him about his level of identification with

Maori culture, and his iwi/hapu/whānau. Then she asks who wants him to come to counselling and who cares about his wellness.
On the base of what Piripi tells her about his identification with taha Maori, she chooses Durie's holistic model to work with him, including taha wairua (spiritual health), taha hinengaro (emotional/mental health), taha tinana (physical health) and taha whānau (family health).
The counsellor asks about *pre-session change* and learns that he has not gambled for one week (his exception) and he uses three strategies to help himself: 1) self-talking – e.g., 'do not go there, you can do it'; 2) reminding himself about the devastating effects of his gambling on himself and his whānau; 3) avoiding gambling venues. On the scale of his experience of problem gambling, where 1/10 is completely out of his control, 10/10 is fully under his control, Piripi gives himself a 2/10 for now and wants to move up to a 7/10 where he would be able to walk away from a gambling venue after spending $10 and go there once a week.
The counsellor assists Piripi to explore solutions from his culture, she asks what the common ideas are about gambling, what types of gambling are thought to be acceptable, how his people stay controlled around gambling, who has successfully managed this problem in his community, what Maori healing resources are available, and how will it feel for him to manage his gambling. The counsellor helps Piripi explore his experience of gambling in the context of the bicultural issues in society. By helping him externalize his gambling problem, the counsellor affirms the effect of the problem on his life and his whānau, but also points out that the problem does not define him as a person and cannot hold him back from living life to the fullest. Piripi describes his *miracle morning* as he could stop thinking those gambling thoughts, feel relaxed, and live a normal life. Piripi reveals that he has experienced a little bit of this miracle when he first has told his mother about his gambling. The counsellor asks Piripi how his people can notice when he is relaxed, what a normal day will be like, and then what he will be doing.
At the end, the counsellor checks with Piripi about his views on working with a culturally different counsellor, the counselling process, and what he thinks she needs to learn about his culture. The counsellor compliments Piripi's exception, encourages him to keep doing what is working for him so far, expresses her faith in Piripi's ability to reach his goals eventually, and appreciates him for sharing his culture knowledge. Homework for him is to ponder what it takes him to move from 2/10 to 3/10 and what he would be doing if he moved to 3/10.

**Scenario 7**

## Solution Focused Brief Counselling (SFBC) treating problem or pathological gambling

**Vignette case description**

Tiana is a 42-year-old Maori mother of four children. She started gambling in her early thirties and used gambling as a kind of entertainment and also an escape from stress. Tiana's grandmother passed away six months ago, and left her some money. After Tiana has gambled all of the money, she made a counselling appointment. She meets the criteria for pathological gambling based on her DSM-IV-TR and SOGS scores.

The ultimate goal of SFBC is to help the client recognize those workable strategies they already have, and strengthen their commitment to bring about the changes he/she wants. The principles of SFBC are brief, strength-based, goal-focused, client-centred, emphasizing behavioural and attitude change, and inducing creativity for solution-building. Basic SFBC procedures include: 1. Using a *pre-session change* question to discover changes that have occurred between the time the clients made the appointment and the time they attend it. This is for exploring the client's own solutions; 2. A *scaling* question is often used for goal-setting and progress-measuring; 3. A *miracle morning* question asks clients to draw out a vision of the future when a problem is absent; 4. A *exception*-finding/amplifying question is used to identify what works already and/or may work; 5. At the end of each session, the counsellor gives feedback on the client's possible solution strategies and assigns homework.

**Description of the first session**

The counsellor, a Pakeha male, asks Tiana about *pre-session change* and learns that she has not gambled for one week (her exception) and she uses three strategies to help herself: 1) self-talking – e.g., 'do not go there, you can do it'; 2) reminding herself about the devastating effects of her gambling on herself and her whānau; 3) avoiding gambling venues. On the scale of her experience of problem gambling, where 1/10 is completely out of her control, 10/10 is fully under her control, Tiana gives herself a 2/10 for now and wants to move up to a 7/10 where she would be able to walk away from a gambling venue after spending $10 and go there once a week. Tiana describes her *miracle morning* as she could stop thinking those gambling thoughts, feel relaxed, and live a normal life. Tiana reveals that she has experienced a little bit of this miracle when she has told her husband and her aunty about her problem gambling.

By helping her externalize her gambling problem, the counsellor affirms the effect of the problem on her life, but also points out that the problem does not define her as a person and cannot hold her back from living life to the fullest. At the end, he compliments Tiana's exception, encourages her to keep doing what works for her so far, and expresses his faith in Tiana's ability to reach her goals eventually.

Homework for her is to ponder what it takes to move from 2/10 to 3/10 and what she would be doing if she moved to 3/10.

**Scenario 8**

## Solution Focused Brief Counselling (SFBC)+ Multicultural Counselling (MC) treating problem or pathological gambling

**Vignette case description**

Tiana is a 42-year-old Maori mother of four children. She started gambling in her early thirties and used gambling as a kind of entertainment and also an escape from stress. Tiana's grandmother passed away six months ago, and left her some money. After Tiana has gambled all of the money, she made a counselling appointment. She meets the criteria for pathological gambling based on her DSM-IV-TR and SOGS scores.

The ultimate goal of SFBC is to help the client recognize those workable strategies they already have, and strengthen their commitment to bring about the changes he/she wants. The principles of SFBC are brief, strength-based, goal-focused, client-centred, emphasizing behavioural and attitude change, and inducing creativity for solution-building. Basic SFBC procedures include: 1. Using a *pre-session change* question to discover changes that have occurred between the time the clients made the appointment and the time they attend it. This is for exploring the client's own solutions; 2. A *scaling* question is often used for goal-setting and progress-measuring; 3. A *miracle morning* question asks clients to draw out a vision of the future when a problem is absent; 4. An *exception*-finding/amplifying question is used to identify what works already and/or may work; 5. At the end of each session, the counsellor gives feedback on the client's possible solution strategies and assigns homework.

The main components of MC interviewing include: developing self-awareness in the counsellor's own culture and bias; checking out the client's preference for the counsellor's culture and language; clarify the client's expectations of the counselling process; identifying the client's levels of acculturation; recognizing those expectations the client's family and ethnic community have of her or him; always respecting and valuing the client's worldview of the presenting problem and solutions; building a trusting relationship and appreciating the extra challenge present in cross-cultural relationship; the need to have an awareness of culture-based behaviours; being flexible and creative to those standard techniques; using culture-centred counselling skills and implementing culturally appropriate and relevant interventions.

**Description of the first session**

The counsellor, a Pakeha male, puts Maori flax flowers and a flax weaving basket in the room and places a New Zealand map with Maori iwi on the wall. He explains to Tiana that he does not speak Te Reo and he appreciates the uniqueness of Maori culture. He provides Tiana a list of Maori counselling agencies and Marae-based helpers. He tells Tiana that their cultural (and gender) differences might affect the counselling relationship and checks with Tiana about her counsellor preference. He asks Tiana to tell him any relevant cultural aspects he needs to know for working effectively with her, and checks with her whether she is happy to do this. He invites her to bring a support person to sessions if she wants and also checks with her about her level of identification to Maori culture, and her iwi/hapu/whānau. Then he asks who wants Tiana to come to counselling and who cares about her wellness.

On the base of what Tiana tells him about her identification with taha Maori, he chooses Durie's holistic model to work with her, including taha wairua (spiritual health), taha hinengaro (emotional/mental health), taha tinana (physical health) and taha whānau (family health).

The counsellor asks about *pre-session change* and learns that she has not gambled for one week (her exception) and she uses three strategies to help herself: 1) self-talking – e.g, 'do not go there, you can do it'; 2) reminding herself about the devastating effects of her gambling on herself and her whānau; 3) avoiding gambling venues. On the scale of her experience of problem gambling, where 1/10 is completely out of her control, 10/10 is fully under her control, Tiana gives herself a 2/10 for now and wants to move up to a 7/10 where she would be able to walk away from a gambling venue after spending $10 and go there once a week.

The counsellor assists Tiana to explore solutions from her culture, he asks what the common ideas are about gambling, what types of gambling are thought to be acceptable, how her people stay controlled around gambling, who has successfully managed this problem in her community, what Maori healing resources are available, and how will it feel for her to manage her gambling. The counsellor helps Tiana explore her experience of gambling in the context of the bicultural issues in society. By helping her externalize her gambling problem, the counsellor affirms the effect of the problem on her life and her whānau, but also points out that the problem does not define her as a person and cannot hold her back from living life to the fullest. Tiana described her *miracle morning* as she could stop thinking those gambling thoughts, feel relaxed, and live a normal life. Tiana reveals that she has experienced a little bit of this miracle when she first has told her husband and aunty about her gambling. The counsellor asks Tiana how her people can notice when she is relaxed, what a normal day will be like, and then what she will be doing.

At the end, the counsellor checks with Tiana about her views on working with a culturally different counsellor, the counselling process, and what she thinks he needs to learn about her culture. The counsellor compliments Tiana's exception, encourages her to keep doing what works for her so far, and expresses his faith in Tiana's ability to reach her goals eventually, and appreciates her for sharing her culture knowledge. Homework for her is to ponder what it takes her to move from 2/10 to 3/10 and what she would be doing if she moved to 3/10.

**Scenario 9**

## Solution Focused Brief Counselling (SFBC) treating problem or pathological gambling

**Vignette case description**

Shan Wong is a 58-year-old Asian immigrant male. He had a professional job in his country of origin, but he can only find work as a taxi driver in New Zealand. He is able to gamble during breaks in the day when driving the taxi. His wife speaks better English than Shan, has a job and brings a steady income home. Shan gambles on the pokies in the casino and pubs and eventually he has lost all the couple's savings. Shan's wife made a counselling appointment for him. Shan meets the criteria for pathological gambling based on his DSM-IV-TR and SOGS scores.

The ultimate goal of SFBC is to help the client recognize those workable strategies they already have, and strengthen their commitment to bring about the changes he/she wants. The principles of SFBC are brief, strength-based, goal-focused, client-centred, emphasizing behavioural and attitude change, and inducing creativity for solution-building. Basic SFBC procedures include: 1. Using a *pre-session change* question to discover changes that have occurred between the time the clients made the appointment and the time they attend it. This is for exploring the client's own solutions; 2. A *scaling* question is often used for goal-setting and progress-measuring; 3. A *miracle morning* question asks clients to draw out a vision of the future when a problem is absent; 4. An *exception*-finding/amplifying question is used to identify what works already and/or may work; 5. At the end of each session, the counsellor gives feedback on the client's possible solution strategies and assigns homework.

**Description of the first session**

The counsellor, a senior Pakeha female, asks Shan about *pre-session change* and learns that he has not gambled for one week (his exception) and he uses three strategies to help himself: 1) self-talking – e.g., 'do not go there, you can do it'; 2) reminding himself about the devastating effects of his gambling on himself and his family; 3) avoiding gambling venues. On the scale of his experience of problem gambling, where 1/10 is completely out of his control, 10/10 is fully under his control, Shan gives himself a 2/10 for now and wants to move up to a 7/10 where he would be able to walk away from a gambling venue after spending $10 and go there once a week. Shan describes his *miracle morning* as he could stop thinking those gambling thoughts, feel relaxed, be a family man, and live a normal life. Shan reveals that he has experienced a little bit of this miracle when he has told his brother about his gambling.

By helping him externalize his gambling problem, the counsellor affirms the effect of the problem on his life, but also points out that the problem does not define him as a person and cannot hold him back from living life to the fullest. At the end, she compliments Shan's exception, encourages him to keep doing what works for him so far, and expresses her faith in Shan's ability to reach his goals eventually. Homework for him is to ponder what it takes him to move from 2/10 to 3/10 and what he would be doing if he moved to 3/10.

**Scenario 10**

## Solution Focused Brief Counselling (SFBC) + Multicultural Counselling (MC) treating problem or pathological gambling

**Vignette case description**

Shan Wong is a 58-year-old Asian immigrant male. He had a professional job in his country of origin, but he can only work as a taxi driver in NZ. He is able to gamble during breaks in the day when driving the taxi. His wife speaks better English than him, has a job and brings a steady income home. Shan gambles on the pokies in the casino and pubs and eventually he has lost all the couple's savings. His wife made a counselling appointment for him. Shan meets the criteria for pathological gambling based on his DSM-IV-TR and SOGS scores.

The ultimate goal of SFBC is to help the client recognize those workable strategies they already have, and strengthen their commitment to bring about the changes he/she wants. The principles of SFBC are brief, strength-based, goal-focused, client-centred, emphasizing behavioural and attitude change, and inducing creativity for solution-building. Basic SFBC procedures include: 1. Using a *pre-session change* question to discover changes that have occurred between the time the clients made the appointment and the time they attend it. This is for exploring the client's own solutions; 2. A *scaling* question is often used for goal-setting and progress-measuring; 3. A *miracle morning* question asks clients to draw out a vision of the future when a problem is absent; 4. An *exception*-finding/amplifying question is used to identify what works already and/or may work; 5. At the end of each session, the counsellor gives feedback on the client's possible solution strategies and assigns homework.

The main components of MC interviewing include: developing self-awareness in the counsellor's own culture and bias; checking out the client's preference for the counsellor's culture and language; clarifying the client's expectations of the counselling process; identifying the client's levels of acculturation; recognizing those expectations the client's family and ethnic community have of her or him; always respecting and valuing the client's worldview of the presenting problem and solutions; building a trusting relationship and appreciating the extra challenge present in cross-cultural relationships; the need to have an awareness of culture-based behaviours; being flexible and creative in those standard techniques; using culture-centred counselling skills and implementing culturally appropriate and relevant interventions.

**Description of the first session**

The counsellor, a senior Pakeha female, puts a Chinese tea jar and a bonsai tree on the table during Mr. Wong's sessions. She tells Mr. Wong the language barrier and their cultural (and gender) differences might affect the counselling relationship and asks Mr. Wong whether he needs an interpreter and also inquires about his counsellor preference. She inquires Mr. Wong what the health system is like in his country and what the common perceptions about gambling are. She asks him to tell her about the traditional way of helping and healing in his culture, who are likely to be accepted as healers, what particular dates are not suitable to visit a healer. The counsellor asks Mr. Wong to tell her any relevant cultural aspects she needs to know for working effectively with him, and checks with him whether he is happy to do this.

The counsellor asks about *pre-session change* and learns that he has not gambled for one week (his exception) and he uses three strategies to help himself: 1) self-talking – e.g., 'do not go there, you can do it'; 2) reminding himself about the devastating effects of his gambling on himself and his family; 3) avoiding gambling venues. On the scale of his experience of problem gambling, where 1/10 is completely out of his control, 10/10 is fully under his control, Mr. Wong gives himself a 2/10 for now and wants to move up to a 7/10 where he would be able to walk away from a gambling venue after spending $10 and go there once a week.

The counsellor assists Mr. Wong to explore solutions from his culture, she asks him what types of gambling are thought to be acceptable, how people stay in control of gambling, and how will it feel for him to manage his gambling. She helps Mr. Wong explore his experience of gambling in the context of the immigration situation.

By helping him externalize his gambling problem, the counsellor affirms the effect of the problem on his life, but also points out that the problem does not define him as a person and cannot hold him back from living life to the fullest.

Mr. Wong describes his *miracle morning* as he could stop thinking those gambling thoughts, feel relaxed, be a family man again, and live a normal life. Mr. Wong reveals that he has experienced a little bit of this miracle when he has told his brother about his problem. The counsellor asks Mr. Wong what it means to be a family man, how his family can notice it, what a normal day will be like, and then what he will be doing.

At the end, the counsellor checks with Mr. Wong about how he views working with a culturally different counsellor, the counselling process, and what he thinks she needs to learn about his culture. The counsellor compliments Mr. Wong's exception, encourages him to keep doing what works for him so far, expresses her faith in Mr. Wong's ability to reach his goals eventually and appreciates him for sharing his culture knowledge. Homework for him is to ponder what it takes him to move from 2/10 to 3/10 and what he would be doing if he moved to 3/10.

**Scenario 11**

## Solution Focused Brief Counselling (SFBC) treating problem or pathological gambling

**Vignette case description**

Ping is a 25-year-old Asian immigrant woman, and had a full time job. Ping plays the pokies in the casino and the pubs every day after work. She has borrowed money from loan sharks to fund her gambling. Ping's parents have visited her from overseas and found out about Ping's gambling problem. They have paid the loan sharks for Ping and made a counselling appointment for her. Ping meets the criteria for pathological gambling based on her DSM-IV-TR and SOGS scores.

The ultimate goal of SFBC is to help the client recognize those workable strategies they already have, and strengthen their commitment to bring about the changes he/she wants. The principles of SFBC are brief, strength-based, goal-focused, client-centred, emphasizing behavioural and attitude change, and inducing creativity for solution-building. Basic SFBC procedures include: 1. Using a *pre-session change* question to discover changes that have occurred between the time the clients made the appointment and the time they attend it. This is for exploring the client's own solutions; 2. A *scaling* question is often used for goal-setting and progress-measuring; 3. A *miracle morning* question asks clients to draw out a vision of the future when a problem is absent; 4. An *exception*-finding/amplifying question is used to identify what works already and/or may work; 5. At the end of each session, the counsellor gives feedback on the client's possible solution strategies and assigns homework.

**Description of the first session**

The counsellor, a Pakeha male, asks Ping about *pre-session change* and learns that she has not gambled for one week (her exception) and she uses three strategies to help herself: 1) self-talking – e.g., 'do not go there, you can do it'; 2) reminding herself about the devastating effects of her gambling on herself and her family; 3) avoiding gambling venues. On the scale of her experience of problem gambling, where 1/10 is completely out of her control, 10/10 is fully under her control, Ping gives herself a 2/10 for now and wants to move up to 7/10 where she would be able to walk away from a gambling venue after spending $10 and go there once a week. Ping describes her *miracle morning* as she could stop thinking those gambling thoughts, feel relaxed, be a proper daughter, and live a normal life. Ping reveals that she has experienced a little bit of this miracle when she has told her parents about her gambling.

By helping her externalize her gambling problem, the counsellor affirms the effect of her problem on her life, but also points out that the problem does not define her as a person and cannot hold her back from living life to the fullest. At the end, he compliments Ping's exception, encourages her to keep doing what works for her so far, and expresses his faith in Ping's ability to reach her goals eventually. Homework for her is to ponder what it takes her to move from 2/10 to 3/10 and what she would be doing if she moved to 3/10.

**Scenario 12**

## Solution Focused Brief Counselling (SFBC) + Multicultural Counselling (MC) treating problem or pathological gambling

**Vignette case description**

Ping is a 25-year-old Asian immigrant woman with a full time job. Ping plays the pokies in the casino and the pubs every day after work. She has borrowed money from loan sharks to fund her gambling. Ping's parents have visited her from overseas and found out about Ping's gambling problem. They have paid the loan sharks for Ping and made a counselling appointment for her. Ping meets the criteria for pathological gambling based on her DSM-IV-TR and SOGS score.

The ultimate goal of SFBC is to help the client recognize those workable strategies they already have, and strengthen their commitment to bring about the changes he/she wants. The principles of SFBC are brief, strength-based, goal-focused, client-centred, emphasizing behavioural and attitude change, and inducing creativity for solution-building. Basic SFBC procedures include: 1. Using a *pre-session change* question to discover changes that have occurred between the time the clients made the appointment and the time they attend it. This is for exploring the client's own solutions; 2. A *scaling* question is often used for goal-setting and progress-measuring; 3. A *miracle morning* question asks clients to draw out a vision of the future when a problem is absent; 4. An *exception*-finding/amplifying question is used to identify what works already and/or may work; 5. At the end of each session, the counsellor gives feedback on the client's possible solution strategies and assigns homework.

The main components of MC interviewing include: developing self-awareness in the counsellor's own culture and bias; checking out the client's preference for the counsellor's culture and language; clarifying the client's expectations of the counselling process; identifying the client's levels of acculturation; recognizing those expectations the client's family and ethnic community have on her or him; always respecting and valuing the client's worldview of the presenting problem and solutions; building a trusting relationship and appreciating the extra challenge present in cross-cultural relationship; the need to have an awareness of culture-based behaviours; being flexible and creative in those standard techniques; using culture-centred counselling skills and implementing culturally appropriate and relevant intervention.

**Description of the first session**

The counsellor, a Pakeha male, puts a Chinese tea jar and a bonsai tree on the table during Ping's sessions. He tells Ping the language barrier and their cultural (and gender) differences might affect the counselling relationship and asks Ping whether she needs an interpreter and also inquires about her counsellor preference. He inquires Ping what the health system is like in her country, and what the common perceptions about gambling are. The counsellor asks her to tell him about the traditional way of helping and healing in her culture, who are likely to be accepted as healers, and what particular dates are not suitable to visit a healer. The counsellor asks Ping to tell him any relevant cultural aspects he needs to know for working effectively with her, and checks with her about whether she is happy to do this.

The counsellor asks about *pre-session change* and learns that she has not gambled for one week (her exception) and she uses three strategies to help herself: 1) self-talking

– e.g., ‘do not go there, you can do it’; 2) reminding herself about the devastating effects of her gambling on herself and her family; 3) avoiding gambling venues. On the scale of her experience of problem gambling, where 1/10 is completely out of her control, 10/10 is fully under her control, Ping gives herself a 2/10 for now and wants to move up to a 7/10 where she would be able to walk away from a gambling venue after spending $10 and go there once a week.

The counsellor assists Ping to explore solutions from her culture, he asks her what types of gambling are thought to be acceptable, how people stay in control of gambling, and how will it feel for her to manage this problem. He helps Ping explore her experience of gambling in the context of the immigration situation

By helping her externalize her gambling problem, the counsellor affirms the effect of the problem on her life and her family, but also points out that the problem does not define her as a person and cannot hold her back from living life to the fullest.

Ping describes her *miracle morning* as she could stop thinking those gambling thoughts, feel relaxed, be a proper daughter, and live a normal life. Ping reveals that she has experienced a little bit of this miracle when she has told her parents. The counsellor asks Ping what it means to be a proper daughter, how her parents can notice it, what a normal day will be like, and then what she will be doing.

At the end, the counsellor checks with Ping about how she views working with a culturally different counsellor, the counselling process, and what she thinks he needs to learn about her culture. The counsellor compliments Ping’s exception, encourages her to keep doing what has worked for her so far, expresses his faith in Ping’s ability to reach her goals eventually, and appreciates her for sharing her culture knowledge. Homework for her is to ponder what it takes her to move from 2/10 to 3/10 and what she would be doing if she moved to 3/10.

**Scenario 13**

## Cognitive Behaviour Therapy (CBT) treating problem or pathological gambling

**Vignette case description:**

Michael is a 27-year-old Pakeha male who was introduced to betting on horse races by his parents in his early adolescence. Michael's partner has taken control of the family finances as he often gambles all their money. Recently, Michael stole goods from his work to fund his gambling, but Michael's boss decided to give him a second chance if he would see a counsellor. Michael meets the criteria for pathological gambling based on his DSM-IV-TR and SOGS scores.

CBT is an evidence-based approach with a focus on cognitive and behavioural change. The content of CBT includes correcting cognitive distortions, restructuring cognitive processes, dealing with irrational beliefs and attitudes, reducing dysfunctional thinking and decreasing self-defeating behaviours, as well as providing stress management training and problem-solving skills. The process of CBT is often directive, structured, educative, brief, goal-oriented, action-focused, assisting clients to examine thought patterns, emotional responses, and behavioural reactions; and using reality-checking to dispute irrational core beliefs and co-designing homework or following self-help workbooks.

**Description of the first session**

1) Identify antecedents, behaviour, and consequences: a non-Pakeha female counsellor assesses the severity of Michael's gambling behaviour, and gathers information on the sequence of his behaviours. Michael identifies that feeling bored and negative or passing gambling venues often lead him to gamble, experiencing excitement during gambling, and feeling a range of negative emotions afterwards. 2) Functional analysis: Michael comes to recognize that he has chosen gambling as a way of coping with uncomfortable emotions. 3) Managing the urges to gamble: the counsellor facilitates Michael developing some self-statements that can be useful when he is experiencing urges to gamble. He also agrees to consider the option of using the Self-Exclusion Order to prevent him from entering the venue/s. 4) Exploring alternatives to gambling as a coping strategy: the counsellor helps Michael explore other possibilities to cope with negative emotions instead of gambling. 5) Challenging irrational thinking: Michael believes that he can get a big win if he keeps gambling. The counsellor asks Michael to do some fact-checking from his own experience. 6) Providing education about the gambling harm: the counsellor shows him some information regarding the negative effects of excessively gambling. 7) Identifying high-risk factors for relapsing and a prevention plan: Michael is aware that he needs to pay attention to managing stressors and negative emotions while avoiding contact with gambling information. He also thinks of developing new hobbies. 8) Setting recovery goals: Michael expresses his desire to stop completely at this stage. 9) Training: the counsellor provides him with some stress-reduction skills and ways of dealing with uncomfortable emotions.10) Homework: Michael chooses to pay attention to recognising uncomfortable emotions and practises the urge-control self-statements daily between sessions.

**Scenario 14**

## Motivational Interviewing (MI) treating problem or pathological gambling

**Vignette case description:**

Michael is a 27-year-old Pakeha male who was introduced to betting on horse races by his parents in his early adolescence. Michael's partner has taken control of the family finances as he often gambles all their money. Recently, Michael stole goods from his work to fund his gambling, but Michael's boss decided to give him a second chance if he would see a counsellor. Michael meets the criteria for pathological gambling based on his DSM-IV-TR and SOGS scores.

MI is a process to elicit clients' motivation for change and enhance their commitment to continuing the progress, focusing on problem-solving, emphasizing goal-setting and behavioural change, and providing a structured and directive conversation. MI is not for fixing multiple problems of living, a chaotic lifestyle, or a high need for emotional expression. The main procedures include: 1) Using a Transtheoretical Model to assess a client's stage of change, including *precontemplation, contemplation, preparation, action,* and *maintenance.* Each stage has its own tasks and interventions. 2) Identifying therapy goals that need the client's agreement. 3) Choosing interventions that should match the client's stage of change and facilitate him/her to move to the next level. 4) Inviting the client to take responsibility and promoting self-efficacy. 5) Developing a relapse prevention plan.

**MI Treatment procedures for Michael's case**

1) Assessing Michael's stage of change: the counsellor, a non-Pakeha female, begins the session by asking Michael about his concerns over his gambling and finds out that Michael sees his gambling as both a form of entertainment and a very expensive hobby 2) Clarifying Michael's ambivalence about change and preparing him for a goal-setting task: as Michael is at the contemplation stage, that is having an ambivalent stance about change, the counsellor asks for his view on the cost-benefits of continuing gambling. She facilitates Michael to talk himself into a perspective from which he sees he cannot afford to continue this kind of hobby. Furthermore, the counsellor asks Michael who benefits if he is continually betting on horse races, and what will it be like for him when he becomes free of gambling debts. 3) Choosing matched intervention: the counsellor acknowledges that ambivalence is a common experience when people start thinking about change. She provides Michael with her reflections on his ideas about change, offers feedback on his gambling assessment results, and provides educational information about the risk of gambling. As Michael asks for some coping strategies, the counsellor introduces some gambling behavioural management strategies. 4) Enhancing self-efficacy and responsibility for change: the counsellor affirms Michael's input in the session, encourages him to think of alternative entertainment and a possible plan for change. 5) To prevent him from going back to the precontemplation, the counsellor suggests that he continues to think about change between sessions.

**Scenario 15**

## Cognitive Behavioural Therapy (CBT) treating problem or pathological gambling

**Vignette case description:**

Kate is 20-year-old Pakeha female who started gambling on the pokies two years ago. She won two jackpots on one single day, which was the first time in her life she played the pokies. In the following two years, she has gambled every day and is deeply in debt. Eventually, Kate's parents had bailed her out with the condition that she must go to see a counsellor. Kate meets the criteria for pathological gambling based on her DSM-IV-TR and SOGS scores.

CBT is an evidence-based approach with a focus on cognitive and behavioural change. The content of CBT includes correcting cognitive distortions, restructuring cognitive processes, dealing with irrational beliefs and attitudes, reducing dysfunctional thinking and decreasing self-defeating behaviours, as well as providing stress management training and problem-solving skills. The process of CBT is often directive, structured, educative, brief, goal-oriented, action-focused, assisting clients to examine thought patterns, emotional responses, and behavioural reactions; and using reality-checking to dispute irrational core beliefs and co-designing homework or following self-help workbooks.

**Description of the first session:**

1) Identify antecedents, behaviour, and consequences: a non-Pakeha male counsellor assesses the severity of Kate's gambling behaviour, and gathers information on the sequence of her behaviours. Kate identifies that feeling bored and negative or passing gambling venues often lead her to gamble, experiencing excitement during gambling, and feeling a range of negative emotions afterwards. 2) Functional analysis: Kate comes to recognize that she has chosen gambling as a way of coping with uncomfortable emotions. 3) Managing the urges to gamble: the counsellor facilitates Kate developing some self-statements that can be useful when she is experiencing urges to gamble. She also agrees to consider the option of using the Self-Exclusion Order to prevent her from entering the venue/s. 4) Exploring alternatives to gambling as a coping strategy: the counsellor helps Kate explore other possibilities to cope with negative emotions instead of gambling. 5) Challenging irrational thinking: Kate believes that she can get another jackpot if she keeps feeding the pokies. The counsellor asks Kate to do some fact-checking from her own experience. 6) Providing education about gambling harm: the counsellor shows her some information regarding the negative effects of excessively gambling. 7) Identifying high-risk factors for relapsing and a prevention plan: Kate is aware that she needs to pay attention to managing stressors and negative emotions while avoiding contact with gambling information. She also thinks of developing new hobbies. 8) Setting recovery goals: Kate expresses her desire to stop completely at this stage. 9) Training: the counsellor provides her with some stress-reduction skills and ways of dealing with emotions .10) Homework: Kate chooses to pay attention to recognising uncomfortable emotions and practises the urge-control self-statements daily between sessions.

**Scenario 16**

## Motivational Interviewing (MI) treating problem and/or pathological gambling

**Vignette case description:**

Kate is 20-year-old Pakeha female who started gambling on the pokies two years ago. She won two jackpots on one single day, which was the first time in her life she played the pokies. In the following two years, she has gambled every day and is deeply in debt. Eventually, Kate's parents had bailed her out with the condition that she must go to see a counsellor. Kate meets the criteria of pathological gambling based on her DSM-IV-TR and SOGS scores.

MI is a process to elicit clients' motivation for change and enhance their commitment to continuing the progress, focusing on problem-solving, emphasizing goal-setting and behavioural change, and providing a structured and directive conversation. MI is not for fixing multiple problems of living, a chaotic lifestyle, or a high need for emotional expression. The main procedures include: 1) Using a Transtheoretical Model to assess a client's stage of change, including *precontemplation, contemplation, preparation, action,* and *maintenance.* Each stage has its own tasks and interventions. 2) Identifying therapy goals that need the client's agreement. 3) Choosing intervention that should match the client's stage of change and facilitate him/her to move to the next level. 4) Inviting the client to take responsibility and promoting self-efficacy. 5) Developing a relapse prevention plan.

**MI Treatment procedures for Kate's case**

1) Assessing Kate's stage of change: the counsellor, a non-Pakeha male, begins the session by asking Kate about her concerns over her gambling and finds out that Kate sees her gambling as both a form of entertainment and a very expensive hobby. 2) Clarifying Kate's ambivalence about change and preparing her for a goal-setting task: as Kate is at the contemplation stage, that is having an ambivalent stance about change, the counsellor asks for her view on the cost-benefits of continuing gambling. He facilitates Kate to talk herself into a perspective from which she sees she cannot afford to continue this kind of hobby. Furthermore, the counsellor asks Kate who benefits if she is continually feeding the pokies, and what will it be like for her when she becomes free of gambling debts. 3) Choosing matched intervention: the counsellor acknowledges that ambivalence is a common experience when people start thinking about change. The counsellor provides Kate with his reflections on Kate's ideas about change, offers feedback on her gambling assessment results, and provides educational information about the risk of gambling. As Kate asks for some coping strategies, the counsellor introduces some gambling behavioural management strategies. 4) Enhancing self-efficacy and responsibility for change: the counsellor affirms Kate's input in the session, encourages her to think of alternative entertainment and a possible plan for change. 5) To prevent her from going back to the precontemplation, the counsellor suggests that she continues to think about change between sessions.